OASIS GUIDEBOOK
For
Medicare Certified Home Health Agencies
Revised 8/08

OASIS Regulations
- 42 CFR 484.11 Release of Patient Identifiable OASIS Info
- 42 CFR 484.20 Reporting OASIS Information
- 42 CFR 484.55 Comprehensive Assessments of Patients

CMS Documents Correlated to Specific OASIS MO Items
- OASIS Manual Chapter 8 – Item by Item Review 1/08
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This OASIS Guidebook covers the OASIS Data Set B-1 (1/2008) item-by-item reviews found in Chapter 8 of the OASIS Implementation Manual (1/2008) along with the CMS Questions and Answers following each item.

Note: Refer to the OASIS Implementation Manual 1/08 to review other topics of interest for OASIS data Collection and Transmission. Of particular importance are the Questions and Answers related to:

- Category 1 – Applicability
- Category 2 – Comprehensive Assessment
- Category 3 – Follow-up Assessments
- Category 4 – OASIS Data Set – Forms and Items

This information is available on the following website: ww.qtso.com/hhadownload.html

MEDICARE CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES

OASIS REGULATIONS: Effective 7/99, Revised 7/00 and 12/05 Outcome Assessment and Information Set

§484.11 Condition of participation: Release of patient identifiable OASIS information.

The HHA and agent acting on behalf of the HHA in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data, and may not release patient identifiable OASIS information to the public. [64 FR 3763, Jan. 25, 1999]

§484.20 Condition of participation: Reporting OASIS information.

HHAs must electronically report all OASIS data collected in accordance with §484.55.

(a) Standard: Encoding and transmitting OASIS data. An HHA must encode and electronically transmit each completed OASIS assessment to the State agency or the CMS OASIS contractor, regarding each beneficiary with respect to which such information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.

(b) Standard: Accuracy of encoded OASIS data. The encoded OASIS data must accurately reflect the patient's status at the time of assessment.

(c) Standard: Transmittal of OASIS data. An HHA must—

(1) For all completed assessments, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section,

(2) Successfully transmit test data to the State agency or CMS OASIS contractor,

(3) Transmit data using electronic communications software that provides a direct telephone connection from the HHA to the State agency or CMS OASIS contractor, and

(4) Transmit data that includes the CMS assigned branch identification number, as applicable.

(d) Standard: Data Format. The HHA must encode and transmit data using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set. [64 FR 3763, Jan. 25, 1999](Amended 12/05)

484.55 Condition of participation: Comprehensive assessment of patients.

Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the

current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary.

(a) Standard: Initial assessment visit. (1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

(b) Standard: Completion of the comprehensive assessment. (1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.

(c) Standard: Drug regimen review. The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

(1) The last five days of every 60 days beginning with the start-of-care date, unless there is a—

(i) Beneficiary elected transfer;

(ii) Significant change in condition resulting in a new case-mix assignment; or

(iii) Discharge and return to the same HHA during the 60-day episode.

(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;

(3) At discharge.

(e) Standard: Incorporation of OASIS data items. The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only. [64 FR 3784, Jan. 25, 1999, as amended at 65 FR 41211, July 3, 2000] – SR OASIS TIMS Manual 5/06

CHAPTER 8

OASIS IN DETAIL

A. INTRODUCTION

The OASIS data set has multiple purposes within a home health agency. Because of this, it is imperative to ensure that accurate, high quality data are collected. All clinical staff who collect OASIS data should be aware of five specific aspects of data collection: (1) the patients from whom data are collected, (2) the time points for data collection, (3) the conventions or "rules" to observe in collecting and recording data, (4) the meaning of each OASIS item, and (5) how OASIS data are collected in the context of the comprehensive assessment. The patients who are to receive the comprehensive assessment (and OASIS data collection) were discussed in Chapter 4 of this manual, and the time points also were identified in that chapter. This chapter will address the remaining three aspects of data collection.

B. CONVENTIONS (RULES) TO FOLLOW

Both clinical assessment and outcome measurement depend on the collection and analysis of accurate data. All clinical staff who collect OASIS data should be aware of the basic conventions or "rules" to observe in collecting and recording OASIS data.

- *All the items refer to the patient's USUAL STATUS or condition at the time period or visit under consideration — unless otherwise indicated.* Though patient status can vary from day to day and during a given day, the OASIS response should be selected that describes the patient's status most of the time during the specific day under consideration. While learning or becoming familiar with the OASIS, care providers should read through all scale levels of the activity or attribute being evaluated before selecting the level that best describes the patient's status or capability on the day of the assessment.

  The patient status that is recorded pertains to the day of the assessment unless otherwise indicated. A few OASIS items address events or circum stances that occurred within the 14-day period immediately preceding the assessment (e.g., M0175 - Inpatient Facility Discharge, M0200 - Medical or Treatment Regimen Change, M0510 - Urinary Tract Infection, etc.). These items specifically identify this time period in the wording of the question. Item M0830 - Emergent Care identifies a more open-ended time period of "since the last time OASIS data were collected," which might be up to 60 days. Other than these situations, which are noted in the specific item instructions, all other items address the patient's status, circumstance, or condition on the day of the assessment.

- OASIS items should be completed accurately and comprehensively, and skip patterns should be used correctly. Clinicians should monitor the accuracy and completeness of their own responses as they utilize the data set. Supervisory or clerical staff also may perform visual review to monitor correct observance of the skip logic, particularly when the clinician is being oriented and trained in OASIS data collection. Completeness of the OASIS information is critical for care planning as well as case mix reporting and performance improvement based on outcomes.

  As noted, "skip patterns" are included for selected OASIS items. These patterns allow the care provider to move quickly through the sections of the OASIS that do not apply to the

particular patient. Other than items that are specifically noted to be "skipped," all OASIS items should be answered.

• The follow-up and discharge assessments must be done without reference to the previous values for any health status item. It is critical for data accuracy that the clinician does not merely duplicate items from the prior assessment rather than perform a new comprehensive assessment. Such "carry forward" of data results in error-ridden outcome reports, which are not usable by agencies for performance improvement.

• Minimize the use of "Not Applicable" and "Unknown" answer options. For some OASIS items, response options for "Not Applicable" or "Unknown" are available. We encourage clinicians to limit their use of these categories to situations where no other response is possible or appropriate. OASIS items have been reviewed carefully to determine whether "Not Applicable" or "Unknown" responses for patient health status items are consistent with good clinical practice. In several instances, "Unknown" is an acceptable response at start of care, but is not included as a response for the follow-up or discharge versions of the item because the care provider is expected to be sufficiently aware of the patient's condition or circumstances to provide the information. In almost all cases it is possible to collect the needed information without undue intrusiveness or burden for the patient. If a patient declines to provide information, that should be respected. At the same time the HHA should recognize the clinician's responsibility to complete the assessment using available information.

Because the OASIS items have been worded carefully to include most (item) instructions in the item itself, few specific instructions are required. However, some clinicians are more comfortable if they actually have a list of general instructions for reference. Such a list is found in Attachment A to this chapter. This instruction page can be duplicated and used for agency training.

C. UNDERSTANDING THE MEANING OF EACH OASIS ITEM

The OASIS has undergone several years of development and refinement, as well as use by many home care agencies in various research and demonstration projects. During this process, the most common questions and misunderstandings about the items have been identified. The item-by-item review of the data set is found in Attachment B to this chapter. Each OASIS item is documented, the item definition is provided, the time points for data collection identified, response-specific issues or questions are addressed, and assessment strategies for obtaining the data are suggested. Agencies are encouraged to use this section in training staff and as the first reference source for answering questions.

D. COLLECTING OASIS DATA IN THE CONTEXT OF THE COMPREHENSIVE ASSESSMENT

Agency supervisory and administrative personnel occasionally question how the OASIS items are to be administered. Should the clinician use the OASIS as a structured interview tool by reading all of the items to the patient or family? Unequivocally, this is **not** an appropriate way to complete a patient assessment including OASIS. Instead, the clinician should perform the comprehensive assessment, gathering both interview and observation (or measurement) data as indicated. A few OASIS items clearly require interview of the patient/client or family (e.g., M0380 - Type of Primary Caregiver Assistance), while others are best obtained through observation (e.g., M0464 - Status of Most Problematic [Observable] Pressure Ulcer). Attachment B to this chapter provides specific assessment strategies for each item, to assist clinicians to collect the required information effectively and without unnecessary intrusiveness or burden for the patient. Experience with OASIS items indicates that the requisite information is easily obtained within the context of a routine complete assessment.

Table 8.1 presents the primary components of a home care patient assessment. Clinicians assess and collect information on these components in their own unique sequence, as dictated by circumstances, patient needs, and anticipated care requirements. The table depicts how various OASIS items relate to each of these assessment components, thereby showing where and how the OASIS items are best integrated into the patient assessment activity.

TABLE 8.1: Mapping of OASIS Items into Major Components of An Illustrative Patient Assessment at Start of Care.

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
PREVISIT	
Telephone call prior to visit	M0770
Telephone availability	M0770, M0400, M0410,
Setting appointment time	M0560
VISIT	
Basic demographic information	
• Name, address, age, gender, pay source, etc.	M0010-M0150
Entrance to home	
• Patient's ambulatory status	M0700
• Patient remembered telephone call & appointment	M0560, M0570
Interior of home (as move from one room to another)	M0750
• Odors (urine, feces)	also M0520-M0540
• Kitchen (where you might wash your hands)	
-medications present in bottles or scattered	also M0780-M0800
• Bathroom (where you might wash your hands or what you ask to see to set up aide care plan)	M0670, M0680
-bathtub or shower	
-assistive equipment (grab bars, shower chair)	
-toilet	
-soiled clothes with urine or fecal odor	also M0520-M0540
-medications present in bottles or scattered	also M0780-M0800
History of present condition and symptoms	
• Hospitalization and reasons	M0175-M0190
• Onset of current illness	M0200-M0220
• Other comorbidities (severity and management)	M0250, M0500, M0510
• Presence of high risk factors	M0290
• Life expectancy	M0280
Family/caregiver assistance	
• Living situation	M0300, M0340
• Availability of family/caregiver assistance	M0350, M0360
• Other assistance needed and received	M0360-M0380, M0820
Medication inventory	
• Walk to where meds are kept	M0690-M0700
• Assess knowledge of medication schedule, dosage, etc.	M0410,M0560
• Assess ability to administer prescribed medications	M0780-M0800

TABLE 8.1: (Cont'd) Mapping of OASIS Items into Major Components of An Illustrative Patient Assessment at Start of Care.	
Assessment Component and Elements Within Each Component	**Related Patient Tracking Sheet/OASIS Item(s)**
VISIT (continued)	
Physical assessment	
• Vital signs	
- orthostatic BP	M0690
-comprehension of instructions	M0400, M0560-M0570
• Weight	
-comprehension of instructions	M0400, M0560-M0570
-ability to stand, step on scale	M0690-M0700
• Head	
-vision	M0390
-hearing	M0400
-speech	M0410
• Skin condition	M0440-M0488
• Musculoskeletal and neurological	M0640-M0660, M0780 - M0820
-joint function, grasp, pain, etc.	also M0410-M0430,
-neurologic	M0560
• Cardiorespiratory	
-dyspnea	M0490
-lung sounds; check ability to dress upper body	M0650
-circulation in lower extremities; check ability to dress lower body	M0660
• GI/GU	
-urinary status	M0510-M0530
-bowel status	M0540-M0550
• Nutritional status	M0710-M0720, M0760
Emotional/behavioral status assessment	M0560-M0590, M0610, M0620
ADLs/IADLs	
• Review any information not gathered already in sufficient detail	M0670-M0680, M0730 – M0760
POSTVISIT	
Data review (in preparation for care planning)	
• Primary diagnosis and comorbidities	M0230, M0240
• Severity index	M0240
• Prognosis and rehab prognosis	M0260, M0270
• Need for psychiatric nursing services	M0630
• Need for physical, occupational, or speech therapy	M0826

The "discipline-neutrality" of the OASIS refers to the fact that the items were designed so nurses and therapists can use and administer the OASIS equally effectively. This property of discipline-neutrality has been built into the OASIS to ensure its utility for all planned applications. Staff training and open discussion of the items between and among staff from all disciplines are encouraged. This facilitates uniformity in cross-discipline data collection and reporting.
Some case examples of OASIS items are presented in Attachment C to this chapter. These scenarios provide an opportunity to practice answering OASIS items in response to patient situations. Agencies can also utilize their own patient situations as additional scenarios for the same purpose.

E. SOME UNUSUAL SITUATIONS: HOW TO USE OASIS

A variety of situations that produce questions about patient assessment and OASIS data collection can arise during the home care episode. Following are the situations which most often generate questions and the appropriate agency actions.

Situation	Appropriate Agency Action
Patient's primary pay source for skilled home care changes during the episode of care—from Medicare to an alternate pay source.	1. If the original start of care date is maintained, continue assessments and OASIS data collection/reporting according to that date. Report any new pay source (or delete any that no longer pertain) in an update to M0150 – Current Pay Sources for Home Care or the Patient Tracking Sheet. 2. If the start of care (SOC) date changes to coincide with the pay source change, the patient must be discharged (discharge date to coincide with last visit of "old" pay source). A new comprehensive assessment must occur with the new SOC date.
Patient's primary pay source for home care changes during the episode of care—from other-than Medicare to Medicare.	This situation parallels response 2 (above). Follow the actions described there (i.e., discharge patient on last visit of "old" pay source, conduct new comprehensive assessment at new SOC date). A SOC comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source.

Situation	Appropriate Agency Action
A patient is seen at very infrequent intervals (e.g., every 30 days, every 60 days, every 90 days, etc.). What should be done about the every 60 day comprehensive assessment?	For Medicare and Medicaid patients, an assessment will need to be performed during the five-day period immediately preceding the end of each certification period. Visits scheduled on a monthly or every two-month basis usually can be scheduled into this period. A patient needing a skilled visit only every 90 days will require other arrangements. The visit will be reimbursed only if specifically ordered by the physician and considered to be reasonable, necessary, and a medically predictable skilled need. (The required assessment must occur in the presence of the patient, not be conducted over the telephone.)
My agency has a nurse conduct a comprehensive assessment before the therapist begins a therapy-only case. Thus, the nurse's assessment is done before the start of care (SOC) date. Can we continue this practice?	An assessment done in this manner is not in compliance with the Conditions of Participation. If agency policy dictates that an RN complete the comprehensive assessment, then the RN can complete the assessment after the start of care is established by the PT. The data entry software (HAVEN) and the State system software will generate an error message for a comprehensive assessment done before the SOC date. The SOC comprehensive assessment therefore will be considered to be missing for the episode. Your agency can continue to have a nurse conduct a comprehensive assessment within the first five days of the episode, but it will need to be done either the same date as the therapist's SOC date or afterward. In a therapy-only case, only the therapist's performance of a skilled (reimbursable) service can begin the episode. Alternatively, your agency could modify its policy and allow the therapist to conduct the SOC comprehensive assessment for the therapy-only cases.
What should I do if I learn later that the patient was hospitalized for more than 24 hours? Sometimes I do not learn of this hospitalization until my next visit.	Complete the Transfer to Inpatient Facility form (with or without agency discharge according to your agency's policy). (For M0090 – Date Assessment Completed, record the date you learned of the hospitalization. For M0906 – Discharge/Transfer/Death Date, record the date the patient was transferred to the inpatient facility.) The date you are now seeing the patient becomes the new start (or resumption) of care date, depending on your agency policy.

FREQUENTLY ASKED QUESTIONS

1. How can I make sure that my staff is answering the OASIS items correctly? I'm particularly concerned about one clinician substituting for another when there are vacations, sick days, or other absences.

There are actually two parts to the response to this question (and your concern). First, your agency has considerable potential to impact the accuracy of the OASIS data -- starting with your early training and orientation to OASIS items. Using the training materials provided in this manual (and other updates issued through the OASIS web site) and adhering to the item definitions included in Attachment B to this chapter are a good beginning. Encourage your clinicians to refer to the item-by item information provided in Attachment B when they have questions. The OASIS Web-based Training also provides an excellent training approach. (http://www.oasistraining.org)

This early training and orientation continues as you respond to frequent ly asked questions in your agency. Include the appropriate responses to these questions in newsletters or post them in highly-viewed places in your agency. Staff or team meetings can have a few minutes devoted to OASIS items during the early weeks and months of using the data set. Approaches to data accuracy and data quality monitoring that are included in later sections of this manual also help you to pinpoint areas of difficulty in the way your staff utilizes and responds to OASIS items. Your ongoing attention to data accuracy and integrity will serve as a good example to your clinical staff of the importance of high quality data.

The second part of the response concerns the OASIS items themselves. Recall that the items have been tested for interrater reliability at several points during their development, testing, and ultimate use in demonstration projects. Such reliability testing will continue to occur as the items are modified for various reasons over time.

2. Do different disciplines assess the patient in the same way? I wonder whether the nurse and therapist, when encountering the same situation, actually "see" the same thing.

The precise assessment methods used by different clinicians can vary, not only between disciplines but also between different clinicians in the same discipline. This is the reason why OASIS items that are scales contain more detailed descriptive responses than simply numerical levels. Regardless of the assessment method, the description assists the clinician to determine the appropriate response level for the patient.

As noted in the response to Question 1 (above), the orientation, training, and ongoing monitoring of data accuracy within the agency also can focus on drawing similar conclusions from specific situations. It is particularly appropriate to utilize "real" agency patients in discussions of both assessment practices and appropriate responses to OASIS items. Many agencies have reported that such discussions actually serve to increase the overall clinical competencies of their staff in performing patient assessments.

3. Will there be any further revisions to the OASIS-B1 data set currently posted on the OASIS web site?

The OASIS-B1 (1/2008) data set posted on the Web site is the most current version. It was updated as part of the Department of Health and Human Services (HHS) department-wide initiative to reduce regulatory burdens in health care and to address the concerns of health care providers, state and local governments, and individual Americans who are affected by HHS rules. Please continue to check the OASIS Web site for updates.

ATTACHMENT A TO CHAPTER 8

GENERAL OASIS INSTRUCTIONS

1. OASIS items can be completed by any clinician who performs the comprehensive assessment. The Conditions of Participation and agency policy should determine who is responsible for completing the comprehensive assessment (and OASIS items) if individuals from more than one discipline (e.g., PT and OT) are seeing the patient concurrently.

2. All items refer to the patient's usual status or condition at the time period or visit under consideration -- unless otherwise indicated. Though patient status can vary from day to day and during a given day, the response should be selected that describes the patient's status most of the time during the specific day under consideration.

3. Some items inquire about events occurring within the past 14 days or at a specified point (e.g., discharge from an inpatient facility, ADL status at 14 days prior to start of care, etc.). In these situations, the specific time interval included in the item should be followed exactly.

4. OASIS items that are scales (e.g., shortness of breath, transferring, etc.) are arranged in order from least impaired to most impaired. For example, higher values (further down the list of options) on the transferring scale refer to greater dependence in transferring. This is true whether the scale describes a functional, physiologic, or emotional health status attribute.

5. Collection of data through direct observation is preferred to that obtained through interview, but some items (e.g., frequency of primary caregiver assistance) are most often obtained through interview. When interview data are collected, the patient should be the primary source (or a caregiver residing in the home). An out-of-home caregiver can be an alternate source of information if neither of the others are available, but should be considered only in unusual circumstances. In many instances, a combined observation-interview approach is necessary. For example, by speaking with the patient or informal caregiver while conducting the assessment, the provider can determine whether the observed ability to ambulate is typical or atypical at that time. Such combined approaches of observation and interview occur frequently during most well-conducted assessments, but warrant mention here in order to clarify the meaning of OASIS items.

6. The OASIS items may be completed in any order. Because the data collection is integrated into the clinician's usual assessment process, the clinician actually performing the patient assessment is responsible for determining the precise order in which the items are completed.

7. Unless a skip pattern is indicated (and followed), every OASIS item for the specific time point should be completed.

8. Unless the item is noted as "Mark all that apply," only one answer should be marked.

9. Minimize the selection of "Not Applicable" and "Unknown" answer options.

10. Each agency is responsible for monitoring the accuracy of the assessment data and the adequacy of the assessment process.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
www.qtso.com/hhadownload.html

CATEGORY 4 - OASIS DATA SET: FORMS and ITEMS

Q1. Will there be any further revisions to the OASIS-B1 data set currently posted on the OASIS website?

A1. The most current version of the OASIS data set will always be available on the OASIS website
http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage
When revisions are necessary in the future, we will post them on the website well in advance of their effective dates. [Q&A EDITED 08/07]

Q2. When integrating the OASIS data items into an HHA's assessment system, can the OASIS data items be inserted in an order that best suits the agency's needs, i.e., can they be added in any order, or must they remain in the order presented on the OASIS form?

A2. Integrating the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set would facilitate data entry of the items into the data collection and reporting software. However, it is not mandatory that agencies do this. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the State. As long as the agency can format the required CMS data submission file for transmission to the State agency, it doesn't matter in what order the data are collected.

Q3. Are agencies allowed to modify skip patterns through alternative sequencing of OASIS data items?

A3. While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items EXACTLY as they are written into their own assessment instrument. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function (HAVEN) prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. HAVEN includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than HAVEN to report their data so as long as the data are ultimately presented to the State agency in the required CMS data submission format found on the CMS Website at http://www.cms.hhs.gov/oasis/04_dataspecifications.asp . This file that contains the OASIS data items in the same order as contained on the OASIS data set. [Q&A EDITED 08/07]

Q4. Are any quality assurance tools available to help us verify that our staff is using the OASIS correctly?

A4. We are not aware of any standardized quality assurance tool that exists to verify that clinical

staff members are using OASIS correctly. A variety of audit approaches might be used by an agency to validate the appropriate responses to OASIS items. For example, case conferences can routinely incorporate OASIS items as part of the discussion. Multi-discipline cases with visits by two disciplines on adjacent days can contribute to discussion of specific items. (Note that only one assessment is reported as the 'OASIS assessment.') Supervisory (or peer) evaluation visits can include OASIS data collection by two clinicians, followed by comparison of responses and discussion of any differences. Other approaches to data quality monitoring are included in the *OASIS User's Manual*, Chapter 12 available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp . [Q&A EDITED 08/07]

Q5. How do I cut and paste the OASIS questions on the website into our HHA's own assessment?

A5. We have posted the OASIS data set in both .PDF format, i.e., read only format, and Word format on the OASIS Data Sets page at http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage . [Q&A EDITED 08/07]

Q6. Do you have anything available that would help us integrate the OASIS items into our own assessment?

A6. The most current version of OASIS will be found on the CMS OASIS website. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the M0xxx numbers when integrating to alert clinicians that the M0xxx labeled items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Please refer to Appendix C of the OASIS User's Manual (available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp) for examples of a comprehensive assessment (sample clinical records) showing an integration of the OASIS data items with other agency assessment items for each time point. The OASIS data sets are available on the OASIS Data Sets page at http://www.cms.hhs.gov/HomeHealthQualityInits. [Q&A EDITED 08/07]

Q7: Our agency has been using a typical OASIS form that integrated the comprehensive assessment information with OASIS (as required by the Conditions of Participation) within one single form. We recently decided to use two separate forms. One form is the comprehensive Assessment as stated above and the second is CMS OASIS -B1. Someone told us that this was unacceptable and a single, physically integrated form is required. Is this true?

A7: In order to be compliant with the Medicare Condition of Participation, 484.55, Comprehensive Assessment of Patients, the OASIS Assessment Items must be integrated into the agency's comprehensive assessment forms and arranged in a clinically meaningful manner. The M0 Items may not be kept on a separate form and attached as a separate document to the comprehensive assessment. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #2]

Q8. Is there a separate OASIS admission form that can be used for rehab-only cases where skilled nursing is not involved?

A8. The sample assessment forms (incorporating OASIS items) found on the OASIS Data Sets

page http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage most closely resemble nursing assessments. CMS does not have sample rehab assessment examples, though such assessments have been developed by commercial vendors. If an agency chooses to develop its own rehab-specific assessment forms, the principles for documenting OASIS items into an agency's clinical documentation are outlined in Chapters 4 and 7 of the *OASIS User's Manual* available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. [Q&A EDITED 08/07]

Q9. The start of care (SOC) version of OASIS posted on the OASIS web site shows the description of M0550 with two definers, a) and b). However, the Discharge version does not show both definers. Should the definers be included at all assessment time points?

A9. The a) definer (related to an inpatient stay) is specific to SOC (or resumption of care after an inpatient stay), and Follow-up assessment time points. It is not appropriate for the Discharge and therefore is omitted from that time point version. The data set instructs "*At discharge, omit references to inpatient facility stay." [Q&A EDITED 08/07]

Q10. Are the OASIS data sets (all time points) to become part of the patient's record? Do we keep them in the charts? Of course, our admission OASIS data set will be part of the chart because we have our admission assessment included in the OASIS questions. But with the ROC, Transfer, DC, do we make this part of the record?

A10. The Comprehensive Assessment Final Rules, published January 25, 1999, state that the OASIS data items are to be incorporated into the HHA's own assessments, not only for the start of care, but for all the time points at which an update of the comprehensive assessment is required. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record. Verifying the accuracy of the transmitted OASIS data (part of the condition of participation [CoP] on Reporting OASIS information) requires that the OASIS data be retained as part of the clinical documentation. To access the CoP, go to http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q11. If the OASIS data elements are being filled out for the Start of Care, Follow-up and Discharge, is there an additional nursing note required as a Federal regulation? Or is an additional nursing note (as a summary of data gathered) not required, assuming the OASIS elements include all necessary patient information?

A11. As noted in CFR §484.55 (the condition of participation [CoP] regarding comprehensive assessment), "each patient must receive a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." The preamble to this rule also notes that the OASIS data set is not intended to constitute a complete comprehensive assessment. Each agency must determine, according to their policies and patient population needs, the additional assessment items to be included in its comprehensive assessment forms. Clinical notes are to be completed as required by 42 CFR 484.48 and the home care agency's clinical policies and procedures. To access the CoP, go to http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q12. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat. 2 Q #7]

Q13. In some places in the OASIS User's Manual, the prior 14 days is referred to as being a 'point in time' and in other places, it is referred to as a 'period of time'. Are the '14 days prior' assessment items to be based on what the patient was doing on the 14th day prior to the assessment or on what the patient could usually do the majority of the time during the 14-day period prior to the assessment?

A13. In the ADL/IADL data items (M0640 through M0800), the patient's ability 14 days prior to the start (or resumption) of care is addressed. In these items, 'prior' indicates the patient's status on the 14th day before the start (or resumption) of care. Adhere strictly to this 14-day time point. If the patient was in a hospital at that time, describe the patient's ability on that day. Several other OASIS items (e.g., M0170, M0200, etc.) address events that may have occurred within the last 14 days. In responding to those items, the entire 14-day period should be considered. For example, was the patient discharged from an inpatient facility during the span of 14 days? [Q&A EDITED 08/07]

Q14. There seems to be a discrepancy between the instructions in the OASIS User's Manual regarding M0890, M0895, and M0900. In Appendix B, these three items are omitted from the discharge assessment, yet the items are included in the Inpatient Transfer with Discharge grouping. Should these items be included in the discharge assessment?

A14. The answer to this question depends on whether your agency uses separate assessment forms for Transfer to an Inpatient Facility and for Discharge (not to an inpatient facility). If it has separate forms, these three data items should be included in the assessment for Transfer to Inpatient Facility and not included in the Discharge assessment. On the Transfer to an Inpatient Facility, these items are included in the list of assessment items to be completed. Under Discharge from Agency - Not to an Inpatient Facility, these items are correctly not included. If your agency uses only one form that includes both Transfer and Discharge, however, these items should be included, with notation directing the assessing clinician to only collect these and Transfer (RFA 6 or 7) and not at Discharge (RFA 9). [Q&A EDITED 08/07]

Q15. Our agency has created separate clinical documentation forms for Transfer to Inpatient Facility and for Discharge. On our Discharge form, we omitted M0890, M0895, and M0900 according to the web site information. Yet, when a clinician answers 'hospital' for M0855 on the Discharge form, she is directed to skip to M0890 (which is not included). What should happen in this scenario?

A15. Because your agency has a separate clinical form for Transfer to Inpatient Facility, the clinician should NOT be marking 'hospital' on the Discharge form (for M0855) because a discharge assessment is not correct at the time of transfer. Instead, the clinician should be using the Transfer form, which will direct her/him from M0855 to M0890 when 'hospital' is marked on that form. (M0890, M0895, and M0900 are all included in the Transfer data items.) For HHAs with separate Transfer and Discharge forms, the only correct response to M0855 on the Discharge form is 'NA - No inpatient facility admission.' This is an excellent training reminder to share with your staff.

Q16. [Q&A RETIRED 08/07; Outdated]

Q17. [Q&A DELETED 01/08 due to OASIS data set changes and skip patterns follow-up (RFA 4,5)].

Q18. Unless otherwise indicated, scoring of OASIS items is based on the patient's status on the "day of the assessment." Does the "day of the assessment" refer to the calendar day or the most recent 24- hour period?

A18. Since home care visits can occur at any time of the day, and to standardize the time frame for assessment data, the "day of the assessment" refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient's ability and status, regardless of the time of day of the visit. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #1] [Q&A EDITED 08/07]

Q19: May home health agencies continue to use up their inventory of Patient Tracking Sheets with the 2003 date, since the 1/2008 OASIS changes did not affect these items? If the date at the bottom of the form says that it is 10/2003 will these be noncompliant with any CMS requirements?

A19: Since the OASIS items on the Patient Tracking Sheet (PTS) are not changing in the 01/08 OASIS data set, agencies that have an inventory of PTSs with a 2003 date may continue to use their stock until it is depleted. This exception applies only to the PTS. No other OASIS 2003 data set forms may be used after 01/2008. [Q&A added 1/08; CMS OCCB 1/08 Q&A #2] [Q&A EDITED 05/08]

Q20: I have been getting conflicting information regarding the process for billing Medicare Advantage PPS Payers after 1/1/2008. I have been told that we may need to continue to use the OASIS 1.5 assessment after 1/1/2008 for some of our Medicare Advantage PPS payers. We were planning on moving to 1.6 assessments for all payers. How do we proceed?

A20: The Conditions of Participation require that the current version of the OASIS data must be collected on patients requiring OASIS data collection, including skilled Medicare and CMS OCCB Q&As – January 2008 (www.oasiscertificate.org) Page 3 of 3 Medicaid patients (including Medicare HMOs and replacement plans such as Medicare Advantage). The OASIS 1.6 will be required as of January 1, 2008 (and earlier for patients recertified in the final 5 days of the year for episodes beginning in 2008).

In order to determine a payment amount, Non-Medicare PPS payers (including Medicare HMOs) who choose to pay using a “Medicare PPS-like” model may choose to “upgrade” to the PPS 2008 model (which requires OASIS 1.6), or they may continue to use the original home health PPS model, which may require the agency to provide OASIS 1.5 data (and/or an HHRG calculated from OASIS 1.5 data under the “old” grouper specifications). Home health agencies and payers enter into business arrangements in which both agree to a specific payment methodology and requirements. Such arrangements (like basing payment on the previously required versions of OASIS), do not negate the federal regulatory requirement to collect and submit to the state survey agency the current version of the OASIS items for OASIS-eligible patients. [Q&A added 1/08; CMS OCCB 1/08 Q&A #3] [Q&A EDITED 05/08]

A21: We use a commercial vendor software product for OASIS data collection. When printing their new OASIS 1.60 assessments, the item does not appear exactly as published by CMS (e.g., doesn’t include bolding, underlining) Also, the M0230/M0240/M0246 table or grid is formatted differently on the assessment screens and printouts due to a limited amount of space on the screen. Our vendor has assured us that the OASIS extract and HHRG scores are going to be accurate. Must the OASIS items (on the screen and when printed) match the data set language and format exactly? Or are these kinds of formatting modifications acceptable, as long as the OASIS extract is accurate?

A21: Chapter 2 of the OASIS Implementation Manual directs "The OASIS data set must be incorporated into the HHA's own assessment, exactly as written." Chapter 7 of the Implementation Manual, pg. 7.3, states “Whether paper and pen documentation or a point of service electronic approach is utilized, several general principles for integration of OASIS items must be followed. These include: a. Items in the revised clinical documentation must be exact (verbatim) duplicates of the OASIS items. Emphasis added to items by underlining, boldface, and capitalization must be retained. (In point of service record

keeping systems, such emphasis can be made through use of highlighting approaches other than boldface, but it should be included.) Uniformity of data collection cannot be assured if modifications are made to the items." Additionally, on page 7.9, it states "Ascertain that changes inserted in the forms do not cause parts of one OASIS item to be printed on two different pages or columns."

The OASIS hard copy information for the chart printed out by a point of care system must match the OASIS-B 1.6 data set exactly, including formatting and wording for the items. If the printout of the assessment (i.e., the "hard copy" to be retained in the patient's clinical record) does not match the assessment data entered and submitted to the state, that may be problematic for the following reasons: 1) State surveyors will likely review records and compare the record on site in the agency with the data submitted to the state; 2) If a patient record was requested by the Fiscal Intermediary for medical review, it would be imperative that the printed record match the data collected and submitted to the state (since the same data were used to document the 485 and calculate the billing codes); and 3) One way for an agency to monitor quality is to review responses to OASIS items in clinical records and compare those responses with data collected at prior and subsequent visits to the same patient. If any of these processes would be complicated by the printouts received from your system, it could create problems for the agency.

Due to the size and complexity of M0230/240/246, the formatting may be modified to fit the computer screen as long as the hard copy print out matches the data set and the modification in no way impacts the accuracy of the item scoring. [Q&A added 1/08; CMS OCCB 1/08 Q&A #4] [Q&A EDITED 05/08]

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Category 4B – OASIS Data Items

Q1. PTS. Can the Patient Tracking Sheet be combined with another form such as the agency's referral form?

A1. The agency may choose to use the Patient Tracking Sheet as any other clinical documentation, integrating additional items as desired. If the agency typically collects other items at SOC and updates them only as necessary during the episode of care, these items might be good choices to integrate with the other Tracking Sheet items. The patient's telephone number might be an example of such an item.

Q2. PTS. Can other (agency-specific) items be added to the Patient Tracking Sheet?

A2. The agency can incorporate other items into the Patient Tracking Sheet (PTS) as needed for efficient care provision. Examples of such items that would "fit" nicely with the OASIS PTS items would be the patient's street address, telephone number, or directions to the patient's residence.

Q3. PTS. Must the clinician write down/mark every single piece of information recorded on the Patient Tracking Sheet (e.g., could clerical staff enter the address, ZIP code, etc.)?

A3. Consistent with professional and legal documentation principles, the clinician who signs the assessment documentation is verifying the accuracy of the information recorded. At the time of referral, it is possible for clerical staff to record preliminary responses to several OASIS items such as the address or ZIP code. The assessing clinician then is responsible to verify the accuracy of these data.

Q4. What do the "M000" numbers stand for?

A4. The "M" signifies a Medicare assessment item. The following four characters are numbers that identify the specific OASIS item.

ATTACHMENT B TO CHAPTER 8

OASIS ITEM-BY-ITEM TIPS

OASIS ITEM:
(M0010) Agency Medicare Provider Number: — — — — — —
DEFINITION:
Agency's Medicare provider number
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
Enter the agency's Medicare provider number, if applicable. If agency is not a Medicare provider, leave blank.
ASSESSMENT STRATEGIES:
Agency administrator and billing staff can provide this information. This number may be preprinted on clinical documentation (recommended).

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Category 4B – OASIS Data Items

Q1. M0010 & M0072

1. As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?

2. And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?

A1: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or "CCN"). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it can be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may require NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number.

Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions; they simultaneously use it to report the Primary Referring Physician ID in M0072. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #8]

OASIS ITEM:

(M0014) Branch State: __ __

DEFINITION:

The State where the agency branch office is located.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

Enter the two-letter postal service abbreviation of the State in which the branch office is located. Leave blank if your agency has no branches or all branches are located in the same State.

ASSESSMENT STRATEGIES:

Agency or branch administrator can provide this information.

OASIS ITEM:

(M0016) Branch ID: _ _ _ _ _ _ _ _ _ _

DEFINITION:

Branch identification code, as assigned by the Centers for Medicare & Medicaid Services (CMS). As assigned by CMS, the identifier consists of 10 digits -- the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Enter the Federal branch identification number specified for this branch as assigned by CMS.
- If you are an HHA with no branches, enter "N" followed by 9 spaces.
- If you are a parent HHA that has branches, enter "P" followed by 9 spaces.

ASSESSMENT STRATEGIES:

Agency or branch administrator can provide this information.

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Category 4B – OASIS Data Items

Q1. M0016. What do I enter in M0016 Branch ID after January 1, 2004 if I am an HHA with no branches, a parent, a subunit, or a branch?

A1. If you are a HHA with no branches, please enter "N" followed by 9 spaces. If you are a parent HHA that has branches, please enter "P" followed by 9 spaces. If you are a subunit with no branches, please enter "P" followed by 9 spaces. If you are a branch, enter the Branch ID number assigned by the Regional Office (RO). The Branch identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS assigned branch number.

OASIS ITEM:

(M0020) Patient ID Number: _

DEFINITION:

Agency-specific patient identifier. This is the identification code the agency assigns to the patient and uses for record keeping purposes for this episode of care.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

- The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (e.g., from admission to discharge).
- If there are fewer digits than spaces provided, leave spaces at the end blank.

ASSESSMENT STRATEGIES:

Agency medical records department is the usual source of this number.

OASIS ITEM:

(M0030) Start of Care Date: __ __ /__ __ /__ __ __ __ month day year

DEFINITION:

The date that reimbursable care begins. When the first reimbursable service is delivered, this is the start of care.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- In multidiscipline cases, regulatory requirements (such as the Conditions of Participation) and agency policy will establish which discipline's visit is considered the start of care. A reimbursable service must be delivered to be considered the start of care. For Medicare reimbursement, as explained in 42 CFR 409.46, a physician must specifically order that a particular covered service be furnished and all other coverage criteria must be met for this initial service to be billable and to establish the start of care.
- For skilled PT or SLP to perform the start of care visit for a Medicare patient:
  - the HHA is expected to have orders from the patient's physician indicating the need for physical therapy or SLP prior to the initial assessment visit;
  - no orders are present for nursing at the start of care;
  - a reimbursable service must be provided; and
  - the need for this service establishes program eligibility for the Medicare home health benefit (42 CFR 484.55(a)(2).
- Accuracy of this date is essential; many other aspects of data collection are based on this date.

ASSESSMENT STRATEGIES:

If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

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Category 4B – OASIS Data Items

Q1. M0030. Is the start of care date (M0030) the same as the original start of care when the patient was first admitted to the agency, or is it the start of care for the current certification period?

A1. The start of care date (M0030) is the date of the first reimbursable service and is maintained as the stare of care date until the patient is discharged. It should correspond to the start of care date used for other documentation, including billing or physician orders. [Q&A EDITED 08/07]

Q2. M0030. What if a new service enters the case during the episode? Does it have a different SOC date?

A2. There is only one Start of Care date for the episode, which is the date of the first billable visit.

Q3. M0030. Related to M0030, the 06/06 revisions to Chapter 8 of the OASIS Implementation Manual, have redefined the SOC date to be the day of the first skilled visit. The revisions substituted "skilled" for "reimbursable". Does this mean that once need and eligibility is established, aide visits provided before the first skilled visit are not included in the episode of care? For instance, if PT and HHA are ordered, and a registered nurse does a non-billable initial assessment visit to establish needs and eligibility for a therapy only patient, can't the home health aide make a "reimbursable" visit prior to the day the therapist makes the first "skilled" visit for a Medicare patient? And wouldn't the aide's visit establish the SOC?

A3. CMS Q&A, Category 2, Question 36 clarifies that the "start of care" is defined as the first billable visit. The change in language found on page 8.18 of the 06/06 revision to Chapter 8 of the OASIS Implementation Manual, where the word "reimbursable" was replaced with "skilled" was unintentional and providers are instructed to continue to define the Start of Care as the date the first covered or reimbursable service is provided.

It is possible that the visit that establishes the SOC is not skilled, as in the scenario presented in the question above where the aide's visit is both reimbursable and establishes the start of care for the episode. The Conditions of Participation 484.55, Comprehensive Assessment of Patients Interpretive Guidelines states "For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide." More recent instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services) does state that now, even for Medicare, the first billable visit might be a visit made by a home health aide, once the need and eligibility has been established. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #7]

Q4: If an agency sends an RN out on Sunday to provide a non-billable initial assessment visit for a PT only case and the PT establishes the Start of Care on Monday by providing a billable service, is the 60-day payment episode (485 "From" Date) Sunday or Monday?

A4: The Medicare Benefit Policy Manual explains: **"10.4 - Counting 60-Day Episodes** (Rev. 1, 10-01-03) **HH-201.4 A. Initial Episodes** The "From" date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days."

The “To” date (the 60th day of the payment episode) marks the end of the payment episode for the purposes of determining if a subsequent episode is adjacent or not for M0110 Episode Timing. \

The Start of Care is established when a service is provided that is considered reimbursable by the payer. If an agency sends a clinician to the patient’s home to provide a non-billable service, it does not establish the Start of Care. The Medicare PPS 60 day payment episode (485 From Date) begins on the date the first billable service is provided. In your scenario, the episode begins on Monday when the PT provides a billable service. This guidance can be found in the Medicare Benefit Policy Manual http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf [Q&A added 4/08; CMS OCCB 4/08 Q&A #1] [Q&A EDITED 05/08]

OASIS ITEM:

(M0032) Resumption of Care Date: __ __ /__ __ /__ __ __ __ . **NA – Not Applicable** month day year

DEFINITION:

The date of the first visit following an inpatient stay by a patient currently receiving service from the home health agency.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated when ROC occurs. The resumption of care date must be updated on the Patient Tracking Sheet whenever a patient returns to service following an inpatient facility stay.

RESPONSE—SPECIFIC INSTRUCTIONS:

- At start of care, mark "NA."
- The most recent resumption of care should be entered.
- Agencies who always discharge patients when they are admitted to an inpatient facility will not have a resumption of care date.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

ASSESSMENT STRATEGIES:

If question exists as to the resumption of care date, clarify with the agency administrative staff.

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Category 4B – OASIS Data Items

Q1: M0032. How should resumption of care (ROC) be documented if it occurred in a previous 60day episode/ certification period? What if the latest resumption of care (ROC) was in a previous 60-day episode?

A1: The most recent ROC should be documented, even if it was in a previous 60-day payment episode, as long as the patient has not been discharged from the agency since the most recent

Q2: When a nurse completes a Resumption of Care (ROC) assessment for a PT only case, can the nurse do the ROC on one day and the therapist re-eval the following day? I know this can't be done at SOC, but not sure for ROC since episode has already been established.

A2: The Comprehensive Assessment of Patients Condition of Participation (484.55) (d) states the comprehensive assessment must be completed within 48 hours of the patient's return home from the inpatient facility stay of 24 hours or longer for reasons other than diagnostic testing. It is acceptable for the RN to make a non-billable visit in a PT only case and complete the ROC assessment within 48 hours of discharge and the PT to visit to evaluate either before or after the RN's assessment visit, as long as the PT visit timing meets federal and state requirements, physician's orders, and is deemed reasonable by professional practice standards. The resumption of care date (reported in M0032) is the first visit following an inpatient stay, regardless of who provides it, whether or not the visit is billable, and whether or not the ROC assessment is completed on that first visit. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #1]

OASIS ITEM:
(M0040) Patient Name: (First) (MI) (Last) Suffix)
DEFINITION:
The full name of the patient: first name, middle initial, last name, and suffix (e.g., Jr., III, etc.).
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
• Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important. • If no suffix, leave blank. If middle initial is not known, leave blank. • The name entered should be the patient's legal name, even if the patient consistently uses a "nickname." • The sequence of the names may be reordered (i.e., last name, first name, etc.), if desired.
ASSESSMENT STRATEGIES:
Use the same name as found on the patient's Medicare card, private insurance card, HMO identification card, etc.

Category 4B – OASIS Data Items

Q1: M0040. On M0040, the manual lists the name requirement as 'First, MI, Last, Suffix' but the HAVEN software requires 'Last, First, MI, Suffix.' Can we change the order on our forms to match the software?

A1: Yes.

OASIS ITEM:

(M0050) Patient State of Residence: __ __

DEFINITION:

The State in which the patient is currently residing while receiving home care.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Enter the two-letter postal service abbreviation of the State in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence.

ASSESSMENT STRATEGIES:

Clarify the exact (State) location of the residence with municipal, county, or State officials, if necessary.

OASIS ITEM:

(M0060) Patient Zip Code: __ __ __ __ __ __ __ __ __ __

DEFINITION:

The zip code for the address at which the patient is currently residing while receiving home care.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Enter the zip code for the address of the patient's CURRENT residence.
- Enter at least five digits (nine digits if known).
- The patient's zip code is used on *Home Health Compare* to determine places where your agency provided service. Be sure to use the zip code where the service is provided.

ASSESSMENT STRATEGIES:

Verify the zip code with the local post office, if necessary.

OASIS ITEM:

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ **NA – No Medicare** (including suffix, if any)

DEFINITION:

For Medicare patients only. The patient's Medicare number, including any prefixes or suffixes. Use RRB number for railroad retirement program.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Enter the number identified as "Claim No." on the patient's Medicare card. (NOTE: This may or may not be the patient's Social Security number.)
- If the patient does not have Medicare, mark "NA - No Medicare."
- If the patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number if available. If not available, mark "NA - No Medicare." Do not enter the HMO identification number.
- Enter Medicare number (if known) whether or not Medicare is the primary payment source for this episode of care.
- If there are fewer digits than spaces provided, leave spaces at the end blank.

ASSESSMENT STRATEGIES:

Ask to see the patient's Medicare card. The referring physician may supply the number, but it should be verified with the patient.

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Category 4B – OASIS Data Items

Q1: M0063. If the patient has Medicare, but Medicare is not the primary pay source for a given episode, should the patient's Medicare number be entered?

Q1: The patient's Medicare number should be entered, whether or not Medicare is the pay source for the episode. Keep in mind that Medicare is often a secondary payer, even when another payer will be billed first. In order to bill Medicare as a Secondary Payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150, even though the patient's Medicare number is reported in M0063. [Q&A EDITED 08/07]

OASIS ITEM:

(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ NA – No Medicaid

DEFINITION:

The patient's Medicaid number only.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Include all digits and letters. If patient does not have Medicaid coverage, mark "NA - No Medicaid."
- If the patient has Medicaid, answer this item whether or not Medicaid is the reimbursement source for the home care episode.
- This number is assigned by an individual state and is found on the patient's Medicaid card.

ASSESSMENT STRATEGIES:

Ask to see the patient's Medicaid card or other verifying documentation. Make sure that the coverage is still in effect. The number may be available from the referring physician, but should be verified with the patient. Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency.

OASIS ITEM:

(M0066) Birth Date: __ __ /__ __ /__ __ __ __
month day year

DEFINITION:

Birthdate of the patient, including month, day, and four digits for the year.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for year.

ASSESSMENT STRATEGIES:

Ask the patient or caregiver for the complete birth date. The date may also be obtained from other legal documents (e.g., driver's license, state-issued ID card, etc.).

OASIS ITEM:

(M0069) Gender:

- ☐ 1 - Male
- ☐ 2 - Female

DEFINITION:

The gender of the patient.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Observation or interview.

OASIS ITEM:

(M0072) Primary Referring Physician ID: UK – Unknown or Not Available

DEFINITION:

The six-digit UPIN number.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Write the six digits of the UPIN number. Leave spaces at the end blank if not needed.
- Mark "UK - Unknown or Not Available" if UPIN number is not available.
- This is the same number utilized for Medicare claims information.
- If the referring physician is different from the physician signing the plan of care, use the UPIN number of the latter physician.

ASSESSMENT STRATEGIES:

Obtain physician ID number from physician, medical office, or other provider location.

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Category 4B – OASIS Data Items

Q1: [Q&A DELETED 08/07; Replaced by updated Q&A.]

Q2: M0072. For M0072, are you requesting the ID of the physician who sent the referral or the ID of the primary physician responsible for the patient and who will sign the Plan of Care? They may be different.

A2: If these are different, you should use the same physician information used for filing Medicare (or other) claims to complete M0072. This should be the ID of the physician who signs the plan of care.

Q3: M0010 & M0072

1. As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?

2. And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?

A3: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or "CCN"). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it can be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may require NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number. Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions; they simultaneously use it to report the Primary Referring Physician ID in M0072. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #8]

OASIS ITEM:

(M0080) Discipline of Person Completing Assessment: 1-RN 2-PT 3-SLP/ST 4-OT

DEFINITION:

Identifies the discipline of the clinician completing the comprehensive assessment at the specified time points or the clinician reporting the transfer to an inpatient facility or death at home. LPNs, PTAs, COTAs, MSWs and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment.

TIME POINTS ITEM(S) COMPLETED:

All

RESPONSE—SPECIFIC INSTRUCTIONS:

• Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, only one actually completes and records the assessment.

ASSESSMENT STRATEGIES:

The OASIS data set is designed to be discipline neutral in the wording of the items. According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments. The skilled provider must perform the comprehensive assessment during an actual visit to the patient's home and may not rely on a phone interview with the patient/caregiver or other health care providers. The only exceptions to this requirement for being "in the physical presence of the patient" are the OASIS data provided for Transfer to an Inpatient Facility (with or without agency discharge) or Death at Home. See information on M0100 - Reason for Assessment, Responses 6, 7, and 8 for additional clarification. When both the RN and Physical Therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

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Category 4B – OASIS Data Items

Q1: M0080. Why are Social Workers not included on OASIS item M0080?

A1: In item M0080 - Discipline of Person Completing Assessment, you will find the initials of clinicians (RN, PT, SLP/ST, OT) who can initiate a qualifying Medicare home health service and/or are able to complete the assessment. Social workers are not able to initiate a qualifying Medicare home health benefit or complete the comprehensive assessment, but may support other qualifying services. In the Medicare Conditions of Participation (CoP), CFR 484.34, conducting a comprehensive assessment of the patient is not considered a service that a social worker could provide. To access the CoP, go to http://www.cms.hhs.gov/center/hha.asp, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q2: Can a speech therapist do a non-bill admission for a physical therapy only patient? I have an ST that told me that she has done them for another home care agency and wants to do them for us. I have only allowed an RN or PT to do PT only admits.

A2: The Comprehensive Assessment of Patients Condition of Participation (484.55) states in Standard (a) (2) "When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional." Some agencies' policies make this practice more restrictive by limiting some of the allowed disciplines (i.e., PT, OT, and/or SLP) from completing the initial assessment visit and/or comprehensive assessment, and require an RN to complete these tasks, even in therapy only cases where the therapy discipline establishes program eligibility for the payer. While not necessary, it is acceptable for agencies to implement this type of more stringent/restrictive practice. Even though there are no orders for nursing in a therapy only case, the RN may complete the initial assessment visit and the comprehensive assessment, as nursing, as a discipline, establishes program eligibility for most, if not all payers.

In a case where PT is the only ordered service, and assuming physical therapy services establish program eligibility for the payer, the PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit, and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).

It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be reimbursable visits, therefore would not establish the start of care date for the home care episode. [Q&A added 4/08; CMS OCCB 4/08 Q&A #3] [Q&A EDITED 05/08]

OASIS ITEM:
(M0090) Date Assessment Completed: __ __ /__ __ /__ __ __ __ month day year
DEFINITION:
The actual date the assessment is completed. If agency policy allows assessments to be performed over more than one visit date, the last date (when the assessment is finished) is the appropriate date to record.
TIME POINTS ITEM(S) COMPLETED:
All
RESPONSE—SPECIFIC INSTRUCTIONS:
• If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. • For three of the responses to M0100 (Transfer to Inpatient Facility - patient not discharged from agency; Transfer to Inpatient Facility - patient discharged from agency or Death at Home) record the date the agency learns of the event, as a visit is not necessarily associated with these events. See information on M0100 Reason for Assessment for additional clarification.
ASSESSMENT STRATEGIES:
Note today's date.

Category 4B – OASIS Data Items

Q1: M0090. We have 5 calendar days to complete the admission/start of care assessment. What date do we list on OASIS for M0090 - Date Assessment Completed when information is gathered on day 1, 3 and 5?

A1: Generally, you would enter the last day that assessment information was obtained on the patient in his/her home, if all clinical data items were completed. However, if the clinician needs to follow-up, off site, with the patient's family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last bit of information is collected. [Q&A EDITED 08/07]

Q2: M0090. We had a patient admitted to the hospital on April 15 and found out about it on April 19. When we enter the transfer (patient discharged) assessment (M0100 reason for assessment 7) into HAVEN, we get a warning message that the record was not completed within correct timing guidelines. (M0090) date should be no earlier than (M0906) date AND no more than 2 days after M0906 date.

A2: That message is intended to be a reminder that you should complete a transfer assessment within 48 hours of learning of it. The regulation states that the assessment must be completed within 48 hours of learning of a transfer to an inpatient facility, so in this case, the assessment has been completed in compliance. The warning does not prevent the assessment from being transmitted. If you find that this warning occurs consistently, you may want to examine whether your staff are appropriately tracking the status of patients under their care. [Q&A EDITED 08/07]

Q3: M0090. Is the date that an assessment is completed, in M0090, required to coincide with the date of a home visit? When must the date in M0090 coincide with the date of a home visit?

A3: M0090, date assessment completed, records the date the assessment is completed. The start of care (SOC), resumption of care (ROC), follow-up, and discharge assessments (reason for assessments [RFA] 1, 3, 4, 5, and 9 for M0100) must be completed through an in-person contact with the patient; therefore these assessments will most often coincide with a home visit. The transfer or death at home assessments (RFAs 6, 7, or 8 for M0100) will report in M0090 the date the agency completes the assessment after learning of the event. In the situation where the clinician needs to follow up, off site, with the patient's family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date. [Q&A EDITED 08/07]

Q4: M0090. If an HHA's policy requires personnel knowledgeable of ICD-9-CM coding to complete the diagnosis after the clinician has submitted the assessment, should M0090 be the date that the clinician completed gathering the assessment information or the date the ICD-9-CM code is assigned?

A4: The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. CMS expects that each agency will develop their own policies and procedures and implement them throughout the agency in a manner that allows for correction or clarification of records to meet professional standards. It is appropriate for the clinician to enter the medical

diagnosis on the comprehensive assessment. The HHA can assign a qualified coder to determine the correct numeric code based upon the written diagnosis provided by the assessing clinician. The date at M0090 (Date Assessment Completed) should reflect the actual date the assessment is completed by the qualified clinician. If agency policy allows the assessment to be performed over more than one visit, the date of the last visit (when the assessment is finished is the appropriate date to record. The M0090 date should not necessarily be delayed until coding staff verify the numeric codes. [Q&A added 06/05] [Q&A EDITED 08/07]

Q5: M0090. Should the date in M0090, reflect the date that a supervisor completed a review of the assessment?

A5: While a thorough review by a clinical supervisor may improve assessment completeness and data accuracy, the process for such review is an internal agency decision and is not required. The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected. [Q&A EDITED 08/07]

Q6: M0090. A provider has decided to complete discharge assessments for all patients when payers change because they believe that, by doing so, their reports will better indicate their patients' outcomes. Before making this policy shift they need answers to the following questions:

a. Can the agency perform the RFA 09 and RFA 01 on the same visit?
b. If so, what is the discharge date for the RFA 09 at M0090?
c. If so, what is the admission date for RFA 01 at M0090?
d. Will recording of the same date for both of these assessment result in errors when transmitted to the state agency?

A6: Under normal business practices, one home health visit should not include two types of assessments and be billed to two payer sources. The discharge date for the (RFA 09) Discharge from Agency should be the last date of service for the payer being terminated. The admission date for the new Start of Care (RFA 01) assessment should be the next scheduled visit, according to the plan of care. The agency may send a batch including both assessments to the state system. An edit is in place at the state system to sort for an assessment to close an open patient episode prior to opening a new episode. [Q&A added 06/05]

Q7: M0090. The RN conducted the SOC assessment on Monday. The RN waited to complete the assessment until she could confer with agency therapists after they had completed their therapy evaluations. This communication occurred on Tuesday and included a discussion of the plan of care and the therapists' input on the correct response for M0825. If the RN selects a response for M0825 based on the input from the therapists, does this violate the requirement that the assessment is to be completed by only one clinician? And what is the correct response for M0090, Date Assessment Completed?

A7: Tuesday would be the correct date for M0090. Tuesday was the date the assessing clinician gathered all the information needed to complete the assessment including M0825. In this case, the assessing clinician appeared to need to confer with internal agency staff to confirm the plan of care and the number of visits planned. M0825 is an item which is intended to be the agency's prediction of the number of therapy visits expected to be delivered in the upcoming episode, therefore, an agency practice may include discussion and collaboration among the interdisciplinary team to determine the M0825 response and this would not violate the requirement that the assessment be completed by one clinician. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #2]

Q8: M0090, I understand that M0090, Date Assessment Completed, is the day the last information needed to complete the assessment is colleted, and at discharge, it is generally the last visit. Due to the new Notice of Provider Non-Coverage which must be given to Medicare recipients two days before discharge, there have been occasions when the notice was not signed at the discharge visit. In order to give the patient the 2 day notice, we hold discharging until after they have had the patient sign the notice, and call them back in two days to confirm the discharge plan, however, the OASIS is completed based on the last visit. When this happens, the system gives us an error when we put in the last visit date versus that last discharge date, even though the assessment is based on the last visit.

A8: M0090, Date Assessment Completed, is the date the clinician gathered the last piece of information necessary to complete the assessment. In most cases, but not all, M0090 is the day of a visit. Sometimes the clinician may gather information off site, such as Therapy Need, or other items that are dependent on a call back from a caregiver or physician or other non-patient assessment data like dates. M0906, Discharge Date, is defined by agency policy. For some agency's it is the date of the last visit, but other agencies may define it to be one or two days or more after the last visit. It is not prescribed by regulation, except that the discharge date cannot occur before the date of the last visit. Regulation requires that the discharge assessment must be completed within two calendar days of the actual discharge date or within two calendar days of learning of the need to discharge in the case of an unplanned or unexpected discharge.
In the case you described, the discharge date (M0906) could be defined by the agency's policy as two days after the last visit to allow for the 2 day notice. The clinician would then have up to two calendar days to complete the assessment (M0090). The bulk of the assessment items could be completed on the visit and then M0906 discharge date and M0090 date assessment completed (the last items you needed to complete the assessment) could be determined 2 days after the date of the last visit, once the discharge was a certainty. Establishing a policy that defines the discharge date in this way prevents the problem with the timing of the data submission and is compliant with the regulation. The problem occurs when you complete the assessment (M0090) before the actual discharge date (M0906). [CMS OCCB 10/07 Q&A #9]

Q9: A patient is admitted to Agency A on July 5th, 2007 (with an end of payment episode date of Sept 2nd) , then recertified on Sept 3rd (with an end of episode date November 1st, 2007). Agency B admits on Jan 1, 2008. Is agency B's episode Early or Later?

A9: When determining if 2 eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode. Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1, and continue counting to, and including, the first day o the next episode. In the scenario presented,. In this example, November 1st was the last day of the episode (day 120) and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent. The episode starting January 1st would be reported by Agency B as "early".

December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as "later." All other episodes beginning between November 2 and December 31 in this example would also be reported as "later." [Q&A added 1/08; CMS OCCB 1/08 Q&A #9] [Q&A EDITED 05/08]

Q10: Should the M0090 date be changed when a correction is made after a clinician has completed the assessment but before the assessment is locked? For example, the nurse completes the assessment with a M0826 response of 3 visits on February 1st and records that date at M0090. On Feb 2nd the nurse learns that the therapist assessed the patient and received physician orders for 10 therapy visits. Should the M0090 date be changed to February 2nd to reflect the date that M0826 is corrected?

A10: If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a M0 item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed. [Q&A added 4/08; CMS OCCB 4/08 Q&A # 4] [Q&A EDITED 05/08]

OASIS ITEM:

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Start/Resumption of Care
- o 1 – Start of care—further visits planned .
- o 3 – Resumption of care (after inpatient stay)

Follow-Up
- o 4 – Recertification (follow-up) reassessment **[Go to *M0110*]** .
- o 5 – Other follow-up **[Go to *M0110*]**

Transfer to an Inpatient Facility
- o 6 – Transferred to an inpatient facility—patient not discharged from agency **[Go to *M0830*]** .
- o 7 – Transferred to an inpatient facility—patient discharged from agency **[Go to *M0830*]**

Discharge from Agency — Not to an Inpatient Facility
- o 8 – Death at home **[Go to *M0906*]**
- o 9 – Discharge from agency **[Go to *M0200*]**

DEFINITION:

Identifies the reason why the assessment data are being collected and reported. Accurate recording of this response is important as the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.

TIME POINTS ITEM(S) COMPLETED:

All

RESPONSE—SPECIFIC INSTRUCTIONS:

• Mark only one response.

• Response 1: This is the start of care comprehensive assessment. A plan of care is being established, and further visits are planned. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required, whether or not the patient will be receiving ongoing services.

• Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer (for reasons other than diagnostic tests). Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is marked.

• Response 4: This comprehensive assessment is conducted during the last five days of the 60-day certification period.

• Response 5: This comprehensive assessment is conducted due to a significant change (a major decline or improvement) in patient condition at a time other than during the last five days of the episode. This assessment is done to update the patient's care plan.

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M0100)

• Response 6: Data regarding the patient's transfer to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) are reported. The patient is expected to resume care and is not discharged from the agency. When the patient resumes care, a Resumption of Care comprehensive assessment is conducted. Note the "skip pattern" included in the response. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items.

• Response 7: Data regarding the patient's transfer to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) are reported. The patient is discharged from the agency. Note the "skip pattern" included in the response. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required.

• Response 8: Data regarding patient death other than death in an inpatient facility. A patient who dies before being admitted to an inpatient facility would have this response marked. Note the "skip pattern" included in the response. A home visit is not required to mark this response; a telephone call may provide the information necessary to complete the data items.

• Response 9: This comprehensive assessment is conducted at the patient's discharge from the agency. This discharge is not occurring due to an inpatient facility admission or patient death. An actual patient interaction (i.e., a visit) is required to complete this assessment. Note the "skip pattern" present in the response.

ASSESSMENT STRATEGIES:

Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

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Category 4B – OASIS Data Items

Q1: M0100. Does 'transfer' mean 'transfer to another non-acute setting' or 'transfer to an inpatient facility?'

A1: Transfer means transfer to an inpatient facility, i.e., the patient is leaving the home care setting and being transferred to a hospital, rehabilitation facility, nursing home or inpatient hospice for 24 hours or more for reasons other than diagnostic testing. Note that the text of the item indicates that it means transfer to an inpatient facility. [Q&A EDITED 08/07]

Q2: M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it data entered? Is it transmitted? Is a discharge OASIS completed?

A2: Completion of a SOC Comprehensive Assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system. If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q3: M0100. Which reason for assessment (RFA) should be used when a patient is transferred to another agency?

A3: When a patient is transferred from one agency to another, the patient must be discharged using RFA 9 to enable the new agency to bill for the patient's care.

Q4: M0100. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care unit. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M0855?

A4: Yes, if the patient was admitted to an inpatient facility, the best response to M0100- Reason for Assessment (RFA) is Transfer to an Inpatient Facility. Depending on the agency policy, the choice

may be RFA 6 transfer to an inpatient facility – patient not discharged or RFA 7 transfer to an inpatient facility – patient discharged. The agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M0855. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed, response 1 applies; or a nursing home bed, response 3 applies. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized. [Q&A added 06/05]

Q5: M0100. I understand that when calculating the days you have to complete the comprehensive assessment, the SOC is Day "0". At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day "0", e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Disch/trans/death date. Is M0906 Day "0"?

A5: Yes, when calculating the days you have to complete the comprehensive assessment, the SOC date is day "0". For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day "0". Note that for the purposes of calculating a 60 day episode, the SOC day is day "1". [Q&A ADDED 08/07;
Previously CMS OCCB 07/06 Q&A #3]

Q6: M0100. A patient is admitted to the hospital for knee replacement surgery. During the presurgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility?

A6: No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #4]

Q7: M0100. What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN?

A7: When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency's knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN. The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #5]

Q8: M0100. The CoPs require that the comprehensive assessment be updated within 48

hours of the patient's return home from the hospital. The OASIS Assessment Reference Sheet states that the Resumption of Care assessment be completed within 2 calendar days of the ROC date (M0032), which is defined as the first visit following an inpatient stay. Does this mean that the ROC assessment (RFA 3) must be at least started within 48 hours of the patient's return home, but can take an additional 2 days after the ROC visit to complete?

A8: No. When the agency has knowledge of a hospital discharge, then a visit to conduct the ROC assessment should be scheduled and completed within 48 hours of the patient's return home. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #6]

Q9: M0100. I accidentally completed the RFA 4 – Recertification assessment early (on day 54) for my Medicare patient. I did not realize this until I was into the next certification period. Should I do a new assessment or can the early assessment be used to establish the new case mix assignment for the upcoming episode?

A9: Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should not discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from Haven or Haven-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #7]

Q10: M0100. For the purposes of determining if a hospital admission was for reasons "other than diagnostic tests" how is "diagnostic testing" defined? I understand plain x-rays, UGI, CT scans, etc. would be diagnostic tests. What about cardiac catheterization, an EGD, or colonoscopy? (A patient does receive some type of anesthesia for these). Does the fact that the patient gets any anesthesia make it surgical verses diagnostic?

A10: Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of coronary artery disease (CAD). However, a cardiac catheterization may also be used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. The fact that the procedure requires anesthesia does not determine whether or not the procedure is purely diagnostic or not. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #9]

Q11: M0100 & M0855. HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under "observation status"). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e. no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a hospitalization? How do you answer M0100 & M0855?

A11: In order to qualify for the Transfer to Inpatient Facility OASIS assessment time point, the patient must meet 3 criteria:
1) Be admitted to the inpatient facility (not the ER, not an observation bed in the ER)

2) Reside as an inpatient for 24 hours or longer (does not include time spent in the ER)
3) Be admitted for reasons other than diagnostic testing only.

In your scenario, you are describing a patient that is admitted to the inpatient facility, and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a hospitalization. The correct M0100 response would be either 6-Transfer to an Inpatient Facility, patient not discharged or 7Transfer to an Inpatient Facility, patient discharged, depending on agency policy. M0855 would be answered with Response 1-Hospital as you state the patient was admitted to a hospital. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #10]

Q12: M0100/M0830. Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a "Patient Observation" or "PO" bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?

A12: For purposes of OASIS (M0830) Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M0830.

If from observation status the patient is eventually admitted to the hospital as an inpatient (assuming the transfer criteria are met), then this would trigger the Transfer OASIS assessment, and the agency would complete RFA 6 or RFA 7 data collection, depending on whether the agency chose to place the patient on hold or discharge from home care.

During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence. Outpatient therapy services provided during the period of observation would be included under consolidated billing and should be managed as such. The HHA should always inform the patient of consolidated billing at the time of admission to avoid non-payment of services to the outpatient facility. If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified plan of care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria. The home health agency would bill for this patient as they would for any patient who was seen in an emergency room and returned home without admission to the inpatient facility following guidance in the Medicare Claims Processing manual.

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be

covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

Q13: M0100. An HHA has a patient who has returned home from a hospital stay and they have scheduled the nurse to go in to do the Resumption of Care visit within 48 hours. However, this patient receives both nursing and physical therapy and the PT cannot go in on the 2nd day (tomorrow) and would like to go in today. I have found the standard for an initial assessment visit must be done by a registered nurse unless they receive therapy only. Is this the same case for resumption? Is it inappropriate for the PT to go in the day before and resume PT services and the nurse then to go in the next day and do the ROC assessment update?

A13: The requirement for the RN to complete an initial assessment visit prior to therapy visits in multidisciplinary cases is limited to the SOC time point. At subsequent time points, including the ROC, either discipline (the RN or PT in the given scenario) could complete the ROC assessment. While the assessment must be completed within 48 hours of the patient's return home from the inpatient facility, there is no requirement that other services be delayed until the assessment is completed. Therefore, assuming compliance with your agency-specific policies and other regulatory requirements, there is no specific restriction preventing the PT from resuming services prior to the RN's completion of the ROC assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #12]

Q14: When completing M0110, do we include episodes of care provided in 2007?

A14: When completing M0110, all adjacent Medicare Fee-for-Service episodes should be considered, including those that occurred prior to January 1, 2008. [Q&A added 1/08; CMS OCCB 1/08 Q&A #5] [Q&A EDITED 05/08]

Q15: Since the SCIC assessment is no longer available, what should we do when additional services must be added after the SOC has been submitted and the HHRG established? If a nursing-only patient experiences a fall several weeks into the episode resulting in the initiation of PT, what OASIS assessment should we complete to get additional payment?

A15: The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient's plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

Under PPS 2008, if the patient experiences a major improvement or decline in status after the SOC assessment time frame, assessments should continue to be completed per the CoPs and CMS OCCB Q&As – April 2008 (www.oasiscertificate.org) Page 3 of 10 agency policy, and appropriate care plan changes made per physician orders. In some cases, (e.g., a status decline resulting in an increase in nursing visits for treatment of a new wound) no additional payment would be received, as the Significant Change in Condition (SCIC) payment adjustment has been eliminated with PPS 2008. In cases where the major decline or improvement in the patient's status results in more therapy visits being provided (compared with the number initially reported in M0826 at the SOC), upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during

the episode than were projected at any of the OASIS data collection time points that capture M0826.

No specific action related to OASIS data collection or correction is necessary or expected in order for the agency to receive payment for the actual number of qualified therapy visits provided. [Q&A added 4/08; CMS OCCB 4/08 Q&A #2] [Q&A EDITED 05/08]

OASIS ASSESSMENT REFERENCE SHEET

RFA * Type	RFA Description	Assessment Completed	Locked Date	Submission Timing
01	SOC - further visits planned	Within 5 calendar days after the SOC Date (SOC = Day 0)	Effective 6/21/2006 No required lock date	Effective 6/21/2006 Transmission required within 30 calendar days of completing the assessment (M0090)
03 _ROC - after inpatient stay	Within 2 calendar days of the facility discharge date or knowledge of pt's return home			
04 _Recertification - F/U	The last 5 days of every 60 days, i.e., days 56-60 of the current 60-day period.			
05 _Other F/U	Complete assessment within 2 calendar days of identification of significant change of patient's condition			
06 _Transferred to Inpatient Facility - not discharged from agency	Within 2 calendar days of the disch/trans/death date or knowledge of a qualifying transfer to inpatient facility			
07 _Transferred to Inpatient Facility - discharged from agency	Within 2 calendar days of the disch/trans/death date or knowledge of a qualifying transfer to inpatient facility			
08 _Died at home	Within 2 calendar days of the disch/trans/death date			
09 _Discharged from agency: Not to Inpatient Facility	Within 2 calendar days of the disch/trans/death date			

*** RFA= Reason for Assessment** *RFA 02 and RFA 10 are no longer required records and are rejected by the state system*

(Source: www.cms.hhs.gov/apps/hha/hharefch.asp Modified 7/19/06 to reflect change posted in Federal Register/Vol. 70, #246/Friday, December 23,2005/Rules and Regulations, pg. 76199)

Revisions for RFA 3, 6, & 7 based on CMS 6/05Q&As Cat 2, Questions 2& 8 and 8/06 OCCB Q&As. Revisions to RFA 1 bsed on OASIS-B1 Data Specification Notes July 24, 2003 pg. 6

	Comprehensive Assessment Required?	OASIS Required?	Discharge OASIS Required?	Agency Discharge (Documented Explanation) Required?	
SOC	Only one visit planned & provided	Yes	□ Not required by regulation □ Payer may require OASIS (HHRG items) □ If OASIS collected for payment, and M0150 = 1,2,3, or 4, may be submitted to State system	No	Yes
SOC	More visits planned but none provided after SOC	Yes (may not have been completed, or even started on the first and only visit)	□ Not required by regulation □ Payer may require OASIS (HHRG items) □ If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system	No	Yes
SOC	One visit made, then patient admitted for qualifying inpatient facility stay before 2nd visit	Yes (may not have been completed or even started on the first and only visit)	□ Not required by regulation □ Payer may require OASIS (HHRG items) □ If OASIS collected, and M0150 = 1,2,3,or 4, OASIS data may be submitted to State system □ If SOC OASIS is collected and submitted, may also complete and submit Transfer (RFA 6 or 7), but not required to do so since SOC OASIS is not required	No	Yes
SOC	One visit made but patient died before 2nd visit	Yes (may not have been completed or even started on the first and only visit)	□ Not required by regulation □ Payer may require OASIS (HHRG items) □ If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system □ If SOC OASIS is collected and submitted, may also complete and submit RFA 8 Death at Home, but not required to do so since SOC OASIS is not required	No	Yes
SOC	Visit made but patient not taken under care	No	□ Not Required by regulation	No	No
SOC	RN open (nonbillable) for one time billable therapy visit	Yes	□ Required by regulation □ More than one visit made	Yes □ More than one visit made	Yes

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

	Comprehensive Assessment Required?	OASIS Required?	Discharge OASIS Required?	Agency Discharge (Documented Explanation) Required?	
ROC	Only one visit planned & provided	Yes	Not required by regulation Payer may require OASIS (HHRG items) If OASIS collected for payment, and M0150 = 1,2,3, or 4, may be submitted to State system	No	Yes
ROC	More visits planned but none provided after ROC	Yes	Not required by regulation Payer may required OASIS (HHRG items) If OASIS collected, and M0150 = 1,2,3, or 4, may be submitted to State system	No	Yes
ROC	One visit made, then patient admitted for qualifying inpatient facility stay before 2nd visit	Yes	Not required by regulation Payer may require OASIS (HHRG items) If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system If ROC OASIS is collected and submitted, may also complete and submit Transfer (RFA 6 or 7), but not required to do so since ROC OASIS is not required	No	Yes
ROC	One visit made but patient died before 2nd visit	Yes	Not required by regulation Payer may require OASIS (HHRG items) If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system If ROC OASIS is collected and submitted, may also complete and submit RFA 8 Death at Home, but not required to do so since ROC OASIS is not required	No	Yes
ROC	Visit made but patient not taken under care	No	Not required by regulation	No	No

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

REFERENCES for Guidance:

CMS Q&As Category 2

Q19. An RN visited a patient for Resumption of Care following discharge from a hospital. The nurse found the patient in respiratory distress and called 911. There was no opportunity to complete the Resumption of Care assessment in the midst of this situation. What should be done in this situation?

A19. Any partial assessment that was completed can be filed in the patient record, but HAVEN (or HAVEN-like software) will not allow a partial assessment to be exported for submission to the State agency. In situations like this, a note explaining the circumstances for not completing the assessment should be documented in the chart. If, after the 911 call, the patient is admitted to an inpatient facility and then later returns home again, a Resumption of Care assessment would be indicated at that point. When the 911 call results in the ER treating the patient and sending the patient back home, the Resumption of Care assessment would be completed at the next agency visit.

Q23. A patient recently returned home from an inpatient facility stay. The Transfer comprehensive assessment (RFA 6) was completed. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. She performed CPR and transferred the patient back to the ER where, he passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required?

A23. The Transfer assessment completed the requirements for the comprehensive assessment. The patient did not resume care with the HHA. The agency's discharge summary should be completed to close out the clinical record.

Q42. What should agencies do if the patient leaves the agency after the SOC assessment (RFA 1) has been completed and further visits were expected?

A42. . Completion of a SOC Comprehensive Assessment is required, even when the patient only receives a single visit in an episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a single-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State

system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q43. Since RFAs 2 and 10 were eliminated in December 2002, what should we do if only one visit is made at Resumption of Care? All the references I've seen address only the issue of one visit at SOC.

A43. Because the RFA 10 response originally stated, "after start/resumption of care," we advise you to follow the same instructions you would after only one visit at SOC (i.e., the ROC comprehensive assessment is required, but OASIS data collection is not required). No discharge comprehensive assessment or OASIS is required when no additional visits are made after the ROC visit. Agency clinical documentation should indicate that no additional visits occurred after the ROC assessment, and internal agency documentation of the discharge would be expected. You should be aware that the patient will continue to appear on the agency's roster report as an incomplete episode. The patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would get a warning that the new assessment was out of sequence. This will not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q46. Home health patients may return to the hospital after a single visit. Some HHAs treat these as one-visit only episodes, do not collect OASIS data, and do not bill the Medicare program. Is this acceptable? In many instances, it appears that the patients were prematurely discharged from the hospital.

A46. Yes, this is acceptable. This scenario appears to fit the criteria for one-visit only episodes for Start of Care or Resumption of Care that became effective December 16, 2002. Each patient must receive a comprehensive assessment. The agency is not required to collect the OASIS items, nor encode and submit the assessment. This assessment can be placed in the clinical record for documentation and planning purposes.
[Q&A added 06/05] [Q&A EDITED 08/07]

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

Q58: Medicare patient goes to hospital, agency completes RFA 6, Transfer, patient not discharged. Patient returns home with orders for one PT visit to evaluate new equipment. PT does eval and determines no further visits are necessary. Should HHA complete ROC, even though no further visits are going to be provided? And if the HHA completes the ROC, would they complete a DC on the same day?

A58: In responding to the question, it will be assumed that the single PT visit conducted at the resumption of care was a skilled and covered visit, that the resumption of care visit occurred within the existing 60-day episode, and that we are discussing a Medicare PPS patient.

A comprehensive assessment must be completed when the patient returns home from an inpatient stay of 24 hours or greater for any reason other than diagnostic tests, even though there will only be the one PT visit. The Conditions of Participation 484.55 Comprehensive Assessment of Patients, Standard (d) states: The comprehensive assessment must be updated and revised within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.

However, since 2002, OASIS is not a required part of the comprehensive assessment for known one-visit patient episodes. CMS Q&A Cat 2 Q43 clarifies that a ROC comprehensive assessment is required, even if it is the only visit conducted after the inpatient discharge, but that the assessment should be treated like a one-visit only episode at the start of care (i.e., comprehensive assessment is required, but OASIS data collection is not required). While there is not a regulatory requirement to collect OASIS as part of these assessments, there may be a reimbursement requirement by the payer to do so. No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]

CMS OASIS Q&As Category 4b

Q21. M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it data entered? Is it transmitted? Is a discharge OASIS completed?

A21. Completion of a SOC Comprehensive Assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Conditions of Participation: The Comprehensive Assessment of Patients

OASIS Collection Regulation – published January 1999

§484.55 Condition of participation:

Comprehensive assessment of patients.

(b) *Standard: Completion of the comprehensive assessment.*

(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph

(b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech- language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy established program eligibility.

(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

(1) Every second calendar month beginning with the start of care date;

(2) Within 48 hours of the patient's

return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;

(3) At discharge.

[Excerpt from 64 FR 3784, Jan. 25, 1999] www.access.gpo.gov/su_docs/fedreg/a990125c.html

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

OASIS-B1 (12/2002) Data Set - Approved Final Version

The Centers for Medicare & Medicaid Services (CMS) announces the approval by the Office of Management and Budget (OMB) of the proposed changes to the reduced burden OASIS in response to the Department of Health and Human Services department-wide initiative to reduce regulatory burden in healthcare. Since the reason for assessment 2 -Start of care with no further visits planned has been eliminated, agencies should follow these recommendations if a patient needs only one visit in the episode. According to the Condition of Participation at 42 CFR 484.55, each patient must receive a comprehensive assessment. However, in this case, the agency is not required to collect the OASIS items and the agency is not required to encode or submit that assessment. This assessment can be placed in the clinical record for documentation and planning purposes. A discharge assessment is no longer required for one-visit episodes.

If the home health agency has a Medicare fee-for-service patient and expects to receive payment for the single visit, agencies must follow the PPS payment rules. This means, that for payment for Medicare fee-for-service patients, you must encode and submit reason for assessment 1 for patients with one-time only no further visits planned episodes

Since we have eliminated reason for assessment 10 - Discharge - no further visits after start of care, there is now no discharge indicator for the patient who had only one visit, is no longer with from the agency, and there is no possibility of completing a discharge assessment. If there is only one visit made and the patient is no longer available, no discharge assessments are required.

[Excerpt from "OASIS-B1 (12/2002) Data Set – Approved Final Version]
http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	**OASIS Assessment: M0100 & M0826 Response Selection & Comments**
1. Initiation of home care for new Medicare PPS patient.	**Start of Care: (M0100) RFA 1** and **(M0826)** enter number of therapy visits indicated for the upcoming 60-day episode, or enter 000 if no therapy visits indicated. o OASIS data elements are not required for Private Pay individuals effective December 2003. o Requirements for non-Medicare patients are found at: http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp Select fiscal year 2004 memorandum 04-26.
2. a) New 60-day episode resulting from discharge with all goals met and return to same HHA during the 60-day episode. (PEP Adjustment applies) b) New 60-day episode resulting from transfer during the 60-day episode to HHA with no common ownership. (PEP Adjustment applies to original HHA)	**Start of Care: (M0100) RFA 1** and **(M0826)** enter number of therapy visits indicated for the upcoming 60-day episode, or enter 000 if no therapy visits indicated.
3. New 60-day episode resulting from transfer during the 60-day episode to HHA with common ownership.	For the remainder of the current episode: o Receiving HHA completes any required OASIS collection on behalf of the Transferring HHA. o PEP Adjustment does not apply if patient transfers to HHA with common ownership during a 60-day episode. o The Transferring HHA will serve as the billing agent through the end of the episode in which the transfer occurred. At the end of the episode: OPTION 1: NEW PAYMENT EPISODE (Recommended) Receiving HHA completes a **Discharge assessment (M0100) RFA 9** on behalf of the Transferring HHA Then Receiving HHA conducts a **Start of Care assessment (M0100) RFA 1**, establishing a new episode and certification, and completing all required admission paperwork. OPTION 2: CONTINUATION OF CURRENT PAYMENT EPISODE Receiving HHA continues to complete OASIS assessments at required Timepoints on behalf of the Transferring HHA. Transferring HHA remains the billing agent.

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	**OASIS Assessment: M0100 & M0826 Response Selection & Comments**
4. Qualifying Inpatient Stay with return to agency during (but not in last 5 days of) the current episode.	OPTION 1: CONTINUATION OF CURRENT PAYMENT EPISODE (RECOMMENDED) *at admission to hospital:* **Transfer without HHA discharge (M0100) RFA 6** *at return to home care:* **Resumption of Care (M0100) RFA 3** and **(M0826)** enter number of therapy visits indicated for current episode, or enter 000 if no therapy visits indicated. OPTION 2: NEW PAYMENT EPISODE UPON RESUMPTION OF CARE *at admission to hospital:* **Transfer with HHA discharge (M0100) RFA 7** *at return to home care* **Start of Care (M0100) RFA 1** and **(M0826)** enter number of therapy visits indicated for upcoming 60-day episode, or enter 000 if no therapy visits indicated. o PEP adjustment applies to original payment episode
5. Qualifying Inpatient Stay with return to agency during the last 5 days of an episode (days 56-60).	OPTION 1: CONTINUATION OF CURRENT PAYMENT EPISODE (RECOMMENDED) *at admission to hospital:* **Transfer without HHA discharge (M0100) RFA 6** *at return to home care:* **Resumption of Care: (M0100) RFA 3** and **(M0826)** enter number of therapy visits indicated, or enter 000 if no therapy visits indicated. o When the requirement to complete a Resumption of Care assessment overlaps with the time period requiring completion of a Recertification assessment, only the Resumption of Care assessment is necessary. o Patient was transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60). HHA completes the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return, as required. o For payment purposes, this assessment serves to determine the case mix assignment for the subsequent certification period o At **(M0826)** enter number of therapy visits indicated, or enter 000 if no therapy visits indicated, based on therapy need for the subsequent certification period beginning after the end of the current payment episode. o A new Plan of Care is required for the subsequent 60-day episode. OPTION 2: NEW PAYMENT EPISODE UPON RESUMPTION OF CARE *at admission to hospital:* **Transfer with HHA discharge (M0100) RFA 7** *at return to home care:* **Start of Care (M0100) RFA 1** and **(M0826)** enter number of therapy visits indicated for the 60 days starting with the resumption of care, or enter 000 if no therapy visits indicated. o PEP adjustment applies to original payment episode.
6. Patient experiences a major decline or improvement (as defined by agency) without qualifying inpatient admission.	**Other Follow-Up Assessment: (M0100) RFA 5** and **(M0826)** enter number of therapy visits indicated for the current episode, or enter 000 if no therapy visits indicated. o Although Significant Change in Condition (SCIC) adjustments are no longer available after 01/01/2008, regulatory requirements continue to mandate a comprehensive assessment update when the patient experiences a major decline or improvement in health status, as defined by the agency.

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	**OASIS Assessment: M0100 & M0826 Response Selection & Comments**
7. Subsequent 60-day episode due to the need for continuous home health care after an initial 60 day episode.	**Recertification (Follow-up):** Conduct **(M0100)** RFA 4 assessment during days 56-60 of current payment episode. At **(M0826)** enter number of therapy visits indicated for the subsequent payment episode (60 days), or enter 000 if no therapy visits indicated.
8. Patient's inpatient stay extends beyond the end of the current certification period. (Patient returns to agency after day 60 of the certification period.) - No Recertification assessment has been completed.	*at admission to hospital:* **Transfer with/without HHA discharge (M0100) RFA 6 or 7** *at return to home care:* o HHA will need to complete agency discharge paperwork (not OASIS) before doing a new SOC. o When patient returns home, new orders and plan of care are necessary. o HHA starts new episode and completes a new start of care assessment **(M0100) RFA 1.** o At **(M0826)** enter number of therapy visits indicated for the next 60 days, or enter 000 if no therapy visits indicated.
9. Patient receives a Recertification assessment during days 56-60, then is hospitalized before the end of the certification period. Returns home from inpatient stay on days 60 or 61.	*at recertification:* **Recertification (M0100) RFA 4** and **(M0826)** enter number of therapy visits indicated for the subsequent 60-day payment episode, or enter 000 if no therapy visits indicated. *at admission to hospital:* **Transfer with/without HHA discharge (M0100) RFA 6 or 7** *at return to home care:* **Start of Care/Resumption of Care: (M0100) RFA 1/RFA 3** and **(M0826)** enter number of therapy visits indicated, or enter 000 if no therapy visits indicated. o If **RFA 7** was completed, a new **Start of Care (M0100) RFA 1** is completed upon patient's return home. o If **RFA 6** was completed, a **SOC/ROC** comprehensive assessment is completed. (The HHA will not know if it is a SOC or ROC until the HHRG is calculated). o If the new HHRG is exactly the same as the recertification HHRG, the care is considered continuous. **M0100** should be reported as **RFA 3** and the assessment is a **Resumption of Care**. o If the new HHRG is not exactly the same as the recertification HHRG, the care is not considered continuous and the agency must complete an internal agency discharge (no D/C OASIS required). **M0100** should be reported as **RFA 1** and the assessment is a **Start of Care**, starting a new episode/certification period. New admission paperwork is not necessary, except as required by the payer or agency policy. o See Medicare Claims Processing manual, Chapter 10, Section 80, available at http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
Type of Episode or Adjustment	**OASIS Assessment: M0100 & M0826 Response Selection & Comments**
10. Patient receives a recertification assessment during days 56-60, then experiences a qualifying inpatient admission before the end of the certification period. Returns home from inpatient stay after day 61 (or after the 1st day of the next certification period)	*at recertification* **: (M0100) RFA 4.** At **(M0826),** enter number of therapy visits indicated for subsequent 60-day payment episode, or enter 000 if no therapy visits indicated. *at admission to hospital:* **Transfer with/without HHA discharge (M0100) RFA 6 or 7** *at return to home care:* **Start of Care (M0100) RFA 1** and **(M0826)** enter number of therapy visits indicated for the new payment episode, or enter 000 if no therapy visits indicated. o The episodes are not considered continuous for billing purposes and the agency must complete an internal agency discharge (no D/C OASIS required). A new episode and certification are established, requiring completion of all required admission paperwork. o The RFA 6 or 7 remains as the last OASIS submission under the previous episode.
11. Patient receives a recertification assessment during days 56-60, and then experiences a qualifying inpatient admission in the new episode. o No visits made in the new episode prior to inpatient admission.	*at recertification***: (M0100) RFA 4.** At **(M0826)** enter number of therapy visits indicated for the subsequent 60day episode, or enter 000 if no therapy visits indicated. *at admission to hospital:* **Transfer with/without HHA discharge (M0100) RFA 6 or 7** o If **RFA 7** was completed, a new **Start of Care (M0100) RFA 1** is completed upon patient's return home. o If **RFA 6** was completed, a **SOC/ROC** comprehensive assessment is completed. (The HHA will not know if it is a SOC or ROC until the HHRG is calculated). o If the new HHRG is exactly the same as the recertification HHRG, the care is considered continuous. **M0100** should be reported as **RFA 3** and the assessment is a **Resumption of Care**. (This is an example of when the first visit in the new certification period is a ROC visit.) o If the new HHRG is not exactly the same as the recertification HHRG, the care is not considered continuous and the agency must complete an internal agency discharge (no D/C OASIS required). **M0100** should be reported as **RFA 1** and the assessment is a **Start of Care**, starting a new episode/certification period. New admission paperwork is not necessary, except as required by the payer or agency policy.
12. Pay source changes from any payer to Medicare FFS/PPS	*at discontinuation of previous pay source:* **(M0100) RFA 9** for episode under old pay source (Optional) o Discharge from old pay source is not required but is recommended. *at initiation of Medicare FFS payment:* **Start of Care: (M0100) RFA 1** for new episode under PPS. o A new SOC date is required for Medicare FFS/PPS, as well as a new Plan of Treatment. o The first covered visit after the Medicare FFS is effective establishes the new start of care, and a new SOC assessment should be performed on or within 5 days after this date. o When the old pay source required OASIS data collection, optional completion of the Discharge assessment allows outcomes from eligible episodes to be captured, and for Medicare/Medicaid patients, to contribute to outcome calculations for OBQI and OBQM reports. o It is highly recommended that payer source status be regularly monitored by clinicians to avoid compliance and billing challenges that will result from lacking assessments and missing HHRGs.

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
SPECIAL ISSUES RELATED TO THE TRANSITION TO PPS 2008 – December 27-31, 2007	
Type of Episode or Adjustment	**OASIS Assessment: M0100, M0090 & M0825/6 Response Selection & Comments**
13. **SOC IN 2007 FOR A 2007 EPISODE** Patient admitted to home care during the period December 27, 2007 – December 31, 2007 for an initial 60-day episode that begins prior to January 1, 2008.	**Start of Care: (M0100) RFA 1** o This assessment must be conducted with OASIS-B1 12/2002. o Note that the HHA has 5 days to complete the SOC assessment. If the assessment is completed on 12/27/2007-12/31/2007, at **(M0090)** enter the actual date the assessment is completed. If the assessment is completed in 2008, at **(M0090)** enter the artificial date **"12/31/2007".** At **(M0825)** enter "0-No" or "1-Yes" to indicate if the need for therapy for the upcoming 60-day episode meets the 10-visit therapy threshold. **CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE "12/31/2007" FOR M0090:** o **RFA 1;** o **WHERE THE REQUIRED ASSESSMENT TIME FRAME BEGINS IN 2007 AND ENDS IN 2008; AND** o **THE ACTUAL ASSESSMENT COMPLETION DATE IS IN 2008; AND** o **THE RELATED PAYMENT EPISODE BEGINS IN 2007.**
14. **RECERT in 2007 for a 2008 EPISODE** Patient to be recertified during the period of December 27, 2007 – December 31, 2007 for an subsequent 60-day episode beginning on or after January 1, 2008, due to the need for continuous home health care after an initial 60-day episode.	**Recertification (Follow-up): (M0100)** RFA 4 o This assessment must be conducted with OASIS-B1 1/2008. At **(M0090)** enter the actual date (12/27/2007 – 12/31/2007) the Recertification assessment was completed. At **(M0826)** enter the number of therapy visits indicated for the next 60-day episode, or enter 000 if no therapy visits indicated
15. **RECERT (or OTHER FOLLOW-UP) in 2007 for a 2007 EPISODE** Patient to be recertified during the period of December 27, 2007 – December 31, 2007 for a subsequent 60-day episode beginning prior to January 1, 2008, due to the need for continuous home health care after an initial 60-day episode; OR Patient experienced a major decline or improvement/significant change in condition requiring a Follow-up assessment during the period of December 27, 2007 – December 31, 2007.	**Recertification (Follow-up) or Other Follow-up: (M0100)** RFA 4 or RFA 5 o This assessment must be conducted with OASIS-B1 12/2002. If the actual assessment completion date is 12/27/2007-12/31/2007**, at (M0090)** enter artificial date **"12/26/2007."** At **(M0825)** enter "0-No" or "1-Yes" to indicate if the need for therapy for the 60-day episode meets the 10-visit therapy threshold. o This guidance may generate a warning error message indicating the assessment date is not in compliance with the 5-day window, even though the actual data collection may have occurred in a timely and compliant manner. The HHA need not address this warning message in this special case. o The clinical record should include notation of application of this special scoring guidance in reporting the assessment date, which is required to facilitate appropriate payment during the transition to PPS 2008. **CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE "12/26/2007" FOR M0090:** o **ONLY ON RFA 4 OR RFA 5;** o **WHERE THE ACTUAL ASSESSMENT COMPLETION DATE IS 12/27/2007-12/31/2007; AND** o **THE RELATED PAYMENT EPISODE BEGINS IN 2007.**

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
SPECIAL ISSUES RELATED TO THE TRANSITION TO PPS 2008 – December 27-31, 2007	
16. **ROC in 2007 for a 2008 EPISODE** Qualifying Inpatient Stay with return to agency during the last 5 days of an episode (days 56-60), when o the 5 day recertification window includes at least one day within the December 27-31, 2007 period; AND o the patient needs continuous home health care into a subsequent episode; AND o the 1st day of the new cert period will be on or after January 1, 2008.	OPTION 1: (RECOMMENDED) *at hospital admission:* **Transfer without HHA discharge (M0100) RFA 6** *at return to home care:* **Resumption of Care assessment (M0100) RFA 3**. For **(M0090)**: If the date the assessment is completed is December 27-31, 2007, enter artificial date **"1/1/2008**." If the date the assessment is completed is January 1, 2008 or later, enter the actual date the ROC assessment was completed. o When the requirement to complete a Resumption of Care assessment overlaps with the time period requiring completion of a Recertification assessment, only the Resumption of Care assessment is necessary. (Effective October 1, 2004) o For payment purposes, this assessment serves to determine the case mix assignment for the subsequent 60-day period. o Patient was transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60). The HHA will continue to be required to conduct the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return. o Following this temporary guidance to enter an artificial date may generate a warning error message indicating the assessment date is not compliant with the 2 calendar day time frame for completion of a ROC assessment. The HHA need not address this warning message in this special case. o The reporting of the assessment date will need to follow the above guidance in order to facilitate appropriate payment during the transition to PPS 2008. o The clinical record should include notation of application of this special scoring guidance in reporting the assessment date, which is required to facilitate appropriate payment during the transition to PPS 2008. At **(M0826)** enter the number of therapy visits indicated for the upcoming 60-day episode, or enter 000 if no therapy visits indicated. **CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE "1/1/2008" FOR M0090:** o **ONLY ON RFA 3;** o **WHERE THE 48 HOUR ROC ASSESSMENT TIMEFRAME BEGINS ON OR AFTER 12/27/2007 AND ENDS PRIOR TO 1/1/2008; AND** o **THE RELATED PAYMENT EPISODE BEGINS IN 2008.** *NOTE: Some data systems may not allow entry of a M0090 date later than the current date; in this situation, entry would need to be deferred until 1/1/2008 or later.* OPTION 2: *at hospital admission:* **Transfer with HHA discharge (M0100) RFA 7** *at return to home care during days 56-60 of payment episode:* **new Start of Care assessment: (M0100) RFA 1.** o For episodes starting on/after 1/1/2008, at (**M0090)** enter the actual date the assessment is completed. o For episodes starting on/before 12/31/2007, follow the guidance in Scenario #13 above. PEP adjustment applies to previous episode.

OASIS Considerations for Medicare PPS Patients (Revised October 2007)	
SPECIAL ISSUES RELATED TO THE TRANSITION TO PPS 2008 – December 27-31, 2007	
17. **ROC in 2007 for a 2007 EPISODE** Qualifying Inpatient Stay with return to agency during the last 5 days of an episode (days 56-60), when o the 5 day recertification window includes at least one day within the December 27-31st period; AND o the patient needs continuous home health care into a subsequent episode; AND o the 1st day of the new cert period will be on or before December 31, 2007.	OPTION 1: (RECOMMENDED) *at hospital admission:* **Transfer without HHA discharge (M0100) RFA 6** *at return to home care:* **Resumption of Care assessment (M0100) RFA 3**. o This assessment must be conducted with OASIS-B1 12/2002.. o Note that the HHA has 48 hours to complete the ROC assessment For **(M0090):** If the date the assessment is completed is on or before 12/31/2007, enter the actual date the assessment is completed. If the date the assessment is completed is 1/1/2008 or later, enter artificial date **"12/31/2007."** o When the requirement to complete a Resumption of Care assessment overlaps with the time period requiring completion of a Recertification assessment, only the Resumption of Care assessment is necessary. (Effective October 1, 2004) o For payment purposes, this assessment serves to determine the case mix assignment for the subsequent 60-day period. o Patient was transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60). The HHA will continue to be required to conduct the Resumption of Care assessment (RFA 3) within 48 hours of the patient's return. o The reporting of the assessment date will need to follow the above guidance in order to facilitate appropriate payment during the transition to PPS 2008. o The clinical record should include notation of application of this special scoring guidance in reporting the assessment date, which is required to facilitate appropriate payment during the transition to PPS 2008. At **(M0825)** enter "0-No" or "1-Yes" to indicate if the need for therapy for the upcoming 60-day episode meets the 10-visit therapy threshold. **CRITERIA FOR TEMPORARY WAIVER ALLOWING USE OF ARTIFICIAL DATE 12/31/2007 FOR M0090:** o **RFA 3;** o **WHERE THE REQUIRED ASSESSMENT TIME FRAME BEGINS IN 2007 AND ENDS IN 2008; AND** o **THE ACTUAL ASSESSMENT COMPLETION DATE IS IN 2008; AND** o **THE RELATED PAYMENT EPISODE BEGINS IN 2007.** OPTION 2: *at hospital admission:* **Transfer with HHA discharge (M0100) RFA 7** *at return to home care:* **new Start of Care assessment: (M0100) RFA 1.** o PEP adjustment applies to previous episode. Follow guidance in Scenario #13 above.

For additional guidance describing steps required to create the proper payment group code for claims related to the transition to the refined HH PPS January 1, 2008 please reference: ***"Questions and Answers Regarding Home Health Episodes and the Transition into HH PPS Refinement"*** accessible at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp

OASIS ITEM:

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

- o 1 -Early
- o 2 -Later
- o UK -Unknown
- o NA -Not Applicable: No Medicare case mix group to be defined by this assessment **At Follow-up, go to M0230.**

DEFINITION:

Identifies the placement of the current Medicare payment episode in the patient's current sequence of adjacent Medicare payment episodes.

- A "sequence of adjacent Medicare home health payment episodes" is a continuous series of Medicare payment episodes, regardless of whether the same home health agency provided care for the entire series.
  - o Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted.
  - o "Adjacent" means that there was no gap between Medicare-covered episodes of more than 60 days.
  - o Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as *gap* days when counting the sequence of Medicare payment episodes.
- "Early" means the only episode OR the first or second episode in a sequence of adjacent episodes. • "Later" means the third or later episode in a sequence of adjacent episodes.

TIME POINT ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- Answer "Early" if the Medicare payment episode is the only episode OR the first or second episode in a current sequence of adjacent Medicare home health payment episodes.
- Answer "Later" if the Medicare payment episode is the third or higher in the current sequence of adjacent Medicare home health payment episodes.
- Use the "UK - Unknown" response if the placement of this payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as selecting the "Early" response.
- Enter "NA" if no Medicare case mix group is to be defined for this episode.

ASSESSMENT STRATEGIES:

- Consult all available sources of information to code this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information.
- If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next.
- Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies.
  - o Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of an adjacent episode sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence.

ASSESSMENT STRATEGIES: (cont'd)

- Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).
- If the patient needs a case mix code for billing purposes (a "HIPPS" code), a response to this item is required to generate the code. Some sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate; refer to those payers' guidance on how to respond to this item.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
www.qtso.com/hhadownload.html

Q1: M0110 and M0826, If we determine that we answered M0826, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take?

A1: In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at: http://www.cms.hhs.gov/center/hha.asp it states: "The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M0826) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available."

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient's medical record, if it comes to the clinician's attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected following the agency's correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the State system. For example, if the clinician chose "Early" and during the episode, s/he learned that the patient was in a "Later" episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M0826 that will be required in the upcoming episode. Because M0826 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M0826 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M0826.

Q2: How would an agency report M0110 and M0826 when the patient has a HMO/MCO insurance (and is managed by Medicare) when they require a HIPPS code? What if they *don't* require a HIPPS Code?

A2: If the payer requires an HHRG/HIPPS, M0110 should be answered Early, Later or Unknown and M0826 should reflect the number of reasonable and necessary therapy visits planned for the episode. If the payer does not need the HHRG/HIPPS, M0110 and M0826 should be answered NA.

The agency will need to communicate with their non-Medicare Traditional Fee-for-Service (PPS) patient's payer to determine if they require a HHRG/HIPPS. [Q&A added 1/08; CMS OCCB 1/08 Q&A #12] [Q&A EDITED 05/08]

Q3: When the clinician is unsure if there have been any adjacent episodes, is it better to report M0110 Episode Timing as "early" or "unknown" (which defaults to "early")? If Medicare makes the adjustment automatically to correct this if it was wrong, will it make a difference if we marked "early" vs. "unknown" initially?

A3: The use of the unknown response for M0110 may be impacted by agency preference/practice. Some agencies may choose not to invest the resources necessary to determine whether episodes are early or later episodes, and it is perfectly acceptable for an agency to select "UK" consistently for M0110. Other providers who want to ensure an accurate RAP payment in the case of later episodes may choose to invest the resources to determine which episode the patient is in, and this is also compliant practice. Marking "early" and "unknown" have the same effect on payment calculations. If a M0110 response is determined to be inaccurate at the time of the final claim, payment will be auto-adjusted to the correct episode amount. [Q&A added 1/08; CMS OCCB 1/08 Q&A #7] [Q&A EDITED 05/08]

Q4: How will episode timing work on existing patients that are due for recertification in 2008. Example: Pt admitted in April 2007, due for 5th recert in Feb 2008. Will this be a later episode?

A4: In the scenario you describe, the patient would have had 4 prior adjacent episodes at the point at which you are completing the 5th Recertification assessment in February 2008, so M0110 would be answered with Response "2 – Later", as long as the episodes of care qualify as adjacent episodes. In order to qualify as adjacent, they must have been provided under the Medicare Traditional Fee-for-Service benefit (paid by PPS) and have no more than 60 days from the last day of one episode until the first day of the next episode. Since the episodes were continuous recertifications, and assuming Medicare PPS was the payer for the episodes, these would be considered adjacent episodes. [Q&A added 1/08; CMS OCCB 1/08 Q&A #8] [Q&A EDITED 05/08]

Q5: A patient is admitted to Agency A on July 5th, 2007 (with an end of payment episode date of Sept 2nd), then recertified on Sept 3rd (with an end of episode date November 1st, 2007). Agency B admits on Jan 1, 2008. Is agency B's episode Early or Later?

A5: When determining if 2 eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode.

Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1, and continue counting to, and including, the first day of the next episode. In the scenario presented,. In this example, November 1st was the last day of the episode (day 120) and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent. The episode starting January 1st would be reported by Agency B as "early".

December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as "later." All other episodes beginning between November 2 and December 31 in this example would also be reported as "later." [Q&A added 1/08; CMS OCCB 1/08 Q&A #9] [Q&A EDITED 05/08]

Q6: Agency 1 provides 90 days of care (1 and 1/2 episodes) under Medicare PPS and the patient is discharged. Agency 2 admits under Medicare PPS and begins care at what would have been a day in the 2nd episode (lets say day 45 in the second episode) had agency 1

still been caring for the patient. Is agency 2 still in an early episode? Or is this now a later episode for M0110?

A6: It would be reported as a later episode. Agency 1 provided care for one full payment episode, then recerted to establish a second payment episode, though the patient was discharged before the end of this 2nd episode. A partial episode payment will apply to the 2nd episode when Agency 2 admits the patient to their service under Medicare PPS, and the episode started by Agency 2 will be the third adjacent episode because there was not more than 60 days between the last billable visit provided by Agency 1 and the first billable visit provided by Agency 2. Since it was the third in a series of adjacent episodes, it should be reported as "Later" for M0110. [Q&A added 1/08; CMS OCCB 1/08 Q&A #10] [Q&A EDITED 05/08]

Q7: If a Medicare PPS patient is admitted and discharged with goals met several times within one 60 day period, is each admission counted when determining early vs later episodes? For example, a patient is admitted 10/1 and discharged 10/15 (episode #1-early?), then readmitted 10/30 and discharged 11/15 (episode #2-early?), then readmitted 11/20 (episode #3- later?). Would this represent 3 distinct episodes, for the purpose of determining M0110 Episode Timing?

A7: For M0110, episodes are considered adjacent if there was no greater than 60 days between the last day of one Medicare Fee-for-Service (MC FFS) or PPS payment episode and the first day of the subsequent PPS payment episode. If a home care agency admits a Medicare patient and they had not been in a Medicare FFS Payment episode in the 60 days prior to the admission, the correct M0110 response would be "Early". If this patient was under the Medicare FFS benefit on 10/1 and was then discharged 10/15 and readmitted 10/30, a new payment CMS OCCB Q&As – January 2008 (www.oasiscertificate.org) Page 6 of 6 episode would begin. The agency would receive a partial episode payment for the 10/1 - 10/15 episode. When an episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last billable visit date is the end of the episode. When completing M0110 at the 10/30 episode, the patient would still be in an "Early" episode, as it would be the second in a series of adjacent episodes (assuming there was not an additional adjacent episode previous to the 10/1 episode). If that patient was then discharged on 11/15 (receiving a PEP payment) and readmitted on 11/20, the correct response to M0110 would now be "Later" as the patient would be in the third adjacent episode in the series. [Q&A added 1/08; CMS OCCB 1/08 Q&A #11] [Q&A EDITED 05/08]

Q8: I have entered an assessment into HAVEN, it is ready to be locked and exported, but when I try to calculate the HIPPS Code I receive a message that grouper returned blank values. Why is this?

A8: If M0110 or M0826 are marked as 'Not Applicable' then the Grouper will not return a value for the HIPPS Score. To determine how these fields should be completed please contact your state's OASIS Education Coordinator. [Q&A added 1/08; CMS OCCB 1/08 Q&A #13] [Q&A EDITED 05/08]

Q9: I am uncertain how to answer M0110 in the following situations, please clarify:
a. Payer is Medicare PPS?
b. Payer is a Medicare HMO that requires a HHRG/HIPPS code?
c. Payer is a Medicare HMO that does not require a HHRG/HIPPS code?
d. Payer changes from Medicare PPS to Medicare HMO?

e. Primary payer for skilled home care services does not require a HIPPS code for billing, but Medicare is the secondary payer?
f. M0110 at the Resumption of Care?

A9: Utilize the following grid to determine the correct response for M0110 based upon payer and need for an HHRG/HIPPS code.

Payer	1-Early	2-Later	UK	NA
Medicare PPS	X If 1st or 2nd adjacent PPS episode	X If 3rd or > adjacent PPS episode	X If you don't know, and/or will not be making efforts to find out	X If ROC not in last 5 days of episode
Non-Medicare PPS payer who requires a HHRG			X Always	
Non-Medicare PPS payer who does not require a HHRG				X Always

a. For a Medicare PPS payer, mark 1-Early if 1st or 2nd adjacent episode, mark 2-Later if 3rd or > adjacent episode, mark UK if you don't know and/or will not be making efforts to find out.
b. For a Medicare HMO payer that requires an HHRG/HIPPS, mark UK.
c. For a Medicare HMO payer that does not require an HHRG/HIPPS, mark NA.
d. For a Medicare HMO payer (after pay source change from Medicare PPS), mark UK if the Medicare HMO requires a HHRG/HIPPS, and NA if they do not. Since adjacent episodes should only include those episodes paid by Medicare Fee-for-service (PPS), the new Medicare HMO paid episode will not count when determining episode placement, so it is neither the first or second adjacent episode (early), or the 3rd or higher (later).
e. There is CMS guidance (see CMS OASIS Q&A Category 4b, Q24) that suggests "When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer." **If Medicare PPS is the secondary payer, respond to M0110 the same as if Medicare PPS was the primary payer; mark 1- Early if 1st or 2nd adjacent episode, mark 2-Later if 3rd or > adjacent episode, mark UK if you don't know and/or will not be making efforts to find out.**
f. For M0110 at ROC: M0110 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4), data from M0110 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M0110 is also collected at the ROC (RFA 3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not need for payment, response NA - Not Applicable: No Medicare case mix group to be defined by this assessment could be reported on M0110.

Alternatively, upon ROC, providers may choose to report the same M0110 response that was reported at the SOC (or Recert) assessment that began the current episode, or they could report UK - Unknown. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.

While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending

recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case **if Medicare PPS is a payer; mark 1- Early if the upcoming episode is the 1st or 2nd adjacent episode, mark 2-Later if the upcoming episode is the 3rd or > adjacent episode, mark UK if you don't know and/or will not be making efforts to find out.** [Q&A added 4/08; CMS OCCB 4/08 Q&A #5] [Q&A EDITED 05/08]

Q10: M0110. We had a Medicare patient who received 2 contiguous episodes of service which did not meet the home health benefit. In order to receive payment from a secondary insurer, we submitted demand bills to our intermediary, fully expecting, and receiving denials. One month after being discharged from care, the patient now needs services which do meet Medicare eligibility and we are completing a new SOC to initiate a new episode under Medicare PPS. When answering M0110, should the previous 2 episodes, which were billed to, but denied by the intermediary, be considered when counting adjacent episodes or should they be ignored, since payment under Medicare PPS was denied? For the purposes of defining Medicare PPS episodes for M0110, does it mean the episode was BILLED AND PAID by Medicare PPS, or just that it was BILLED to the Medicare via the RHHI?

A3: At this time, when an agency bills Medicare via the RHHI, an episode is created in the Common Working File (CWF), even if the claim is denied. This payment system problem is in the process of being resolved. Denied episodes should not be counted when determining the correct response to M0110 episode timing. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #3]

OASIS ITEM:

(M0140) Race/Ethnicity (as identified by patient)**: (Mark all that apply.)** .

- o 1 -American Indian or Alaska Native
- o 2 -Asian
- o 3 -Black or African-American
- o 4 -Hispanic or Latino
- o 5 -Native Hawaiian or Pacific Islander
- o 6 -White UK -Unknown

DEFINITION:

The groups or populations to which the patient is affiliated, as identified by the patient or caregiver.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

• Response 1: American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

• Response 2: Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

• Response 3: Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

• Response 4: Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

• Response 5: Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

• Response 6: White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ASSESSMENT STRATEGIES:

Interview patient/caregiver. The patient may self-identify with more than one group; mark all that are noted.

OASIS ITEM:

(M0150) Current Payment Sources for Home Care: (Mark all that apply.) .

- o 0 -None; no charge for current services
- o 1 -Medicare (traditional fee-for-service)
- o 2 -Medicare (HMO/managed care)
- o 3 -Medicaid (traditional fee-for-service)
- o 4 -Medicaid (HMO/managed care)
- o 5 -Workers' compensation
- o 6 -Title programs (e.g., Title III, V, or XX)
- o 7 -Other government (e.g., CHAMPUS, VA, etc.)
- o 8 -Private insurance
- o 9 -Private HMO/managed care
- o 10 -Self-pay
- o 11 -Other (specify)
- o UK -Unknown

DEFINITION:

This item is limited to identifying payers to which any **services** provided during this home care episode and included on the plan of care will be billed by **your home care agency.** Accurate recording of this item is important because assessments for Medicare and Medicaid patients are handled differently than assessments for other payers. If patient is receiving care from multiple payers (e.g., Medicare and Medicaid; private insurance and self-pay; etc.), include all sources. Exclude "pending" payment sources.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated when change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Select Response 2 if the payment source is a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C.
- Select Response 2 if the patient is receiving services provided as part of a Medicare Preferred Provider Organization (PPO) Demonstration program.
- Select Response 3 if the patient is receiving services provided as part of a Medicaid waiver or home and community-based waiver (HCBS) program. • Select Response 6 if the patient is receiving services through one of the following programs:
  - Title III - State Agency on Aging grants, which encourage State Agencies on Aging to develop and implement comprehensive and coordinated community-based systems of service for older individuals via Statewide planning and area planning. The objective of these services and centers is to maximize the informal support provided to older Americans to enable them to remain in their homes and communities. Providing transportation services, in-home services and caregiver support services, this program insures that elders receive the services they need to remain independent;
  - Title V - State programs to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for pregnant women, mothers, infants, and children, and children with special health care needs in providing health services for mothers and children who do not have access to adequate health care;

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M0150)

– Title XX - Social service block grants available to states to provide homemaking, chore service, home management or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate. • Select Response 7 if the patient is a member of a Tri-Care program, which are replacements for CHAMPUS. • If one or more payment sources are known but additional sources are uncertain, mark those that are known. • Mark all current pay sources, whether considered primary or secondary. • Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full.

ASSESSMENT STRATEGIES:

Referral source may provide information regarding coverage. This can be verified with patient/caregiver. Ask patient/caregiver to provide copy of card(s) for any insurance or Medicare coverage. This card will provide the patient ID number as well as current status of coverage. The agency billing office may also have this information. Determine if the patient has any out-of-pocket expenses for services received in the home.

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Category 4B – OASIS Data Items

Q1: M0150. For M0150, Current Payment Sources for Home Care, what should be the response if the clinician knows that a patient has health insurance but that the insurance typically won't pay until attempts have been made to collect from the liability insurance (e.g., for injuries due to an auto accident or a fall in a public place)?

A1: The purpose of this data item is to identify the current payer(s) that your agency will bill for services provided by your agency during this home care episode. Note that the text of M0150 asks for the "current payment source**s**" (emphasis added) and contains the instruction, "Mark all that Apply." For Medicare patients, the clinician should indicate at admission that the patient has Medicare coverage and any other coverage available that the agency will bill for services and mark all of the appropriate responses. The item is NOT restricted to the primary payer source. When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer.. For example, when a Medicare patient is involved in a car accident and someone's car insurance is paying for his/her home care, Medicare is the secondary payer and the response to M0150 should include either response 1 or 2 as appropriate for that patient. The only way an agency can bill Medicare as a secondary payer is to consider that patient a Medicare patient from day 1, so that all Medicare-required documentation, data entry and data submission exist. Although the agency may "intend" that the private pay source will pay the entire cost of the patient's home care that usually cannot be verified at start of care and may not be determined until the care is completed. [Q&A EDITED 08/07]

Q2: M0150. Please clarify what Title V and Title XX programs are?

A2: Title V is a State-determined program that provides maternal, child health, and crippled children's services, which can include home health care. Title XX of the Social Security Act is a social service block grant available to States that provide homemaking, chore services, home management, or home health aide services. (Title III, also mentioned in Response 6 to M0150 is part of the Older Americans Act of 1965 that gives grants to State Agencies on Aging to provide certain services including homemaker, home-delivered meals, congregate nutrition, and personal care aide services at the State's discretion.)

Q3: M0150. A patient with traditional Medicare is referred for skilled services, and upon evaluation, is determined to *not* be homebound, and therefore *not* eligible for the home health benefit. The patient agrees to pay privately for the skilled services. Should M0150 include reporting of response 1 – Medicare (traditional fee-for-service)?

A3: The purpose of M0150 is to identify any and all payers to which any services provided during this home care episode are being billed. Although the patient described is a Medicare beneficiary, response 1 of M0150, Medicare (traditional fee-for-service), would not be marked, since the current situation described does not meet the home health benefit coverage criteria. In fact, since Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients, if the services will not be billed to Medicare or Medicaid, then no OASIS collection would be required for this patient; although, if desired, the agency may voluntarily collect it as part of the still-required comprehensive assessment. If at some point during the care, a change in patient condition results in the patient becoming homebound, and otherwise meeting the home health benefit coverage criteria, then a new SOC assessment would be required, on which response 1 – Medicare (traditional fee-for-service) would be indicated as a payer for the care. [Q&A added

06/05; Previously CMS OCCB 10/04 Q&A #2]

Q4: M0150 The patient's payer source changes from Medicare to Medicaid or private pay. The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source?

A4: There is a discussion of payer source change in Chapter 8, Section E, of the *OASIS User's Manual.* Different States, different payers, and different agencies have varying responses to these payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer that question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source without a discharge. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to http://www.cms.hhs.gov/manuals/104_claims/clm104c10.pdf ; scroll to page 94 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI. [Q&A EDITED 08/07]

Q5: M0150. Which pay sources should be noted when responding to M0150, current payment sources for home care?

A5: All current pay sources should be noted when responding to this item regardless of whether the pay source is primary or secondary. If Medicare and other pay source(s) are paying for care provided by a single agency, all the relevant pay sources should be noted. Note that the text of M0150 contains the instruction, "Mark all that apply."

Q6: M0150. Do I mark response 1 Medicare (traditional fee-for-service) if the patient's payer is the VA?

A6: If the patient has both VA and Medicare and both are expected payers, then you need to mark Response 1, Medicare (traditional fee-for-service) and Response 7, Other government (e.g. CHAMPUS, VA, etc.). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7, Other government (e.g. CHAMPUS, VA, etc.) would be the correct response. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #8]

Q7: M0150. If a patient is receiving Meals-on-Wheels services, do you capture the payment for the service as a Response 10; Self Pay on M0150 Current Payment Sources for Home Care?

A7: No, food is not considered within the scope of M0150. Most patients pay for their food, whether they purchase it directly, a caregiver purchases and delivers it, or a service such as Meals-on-Wheels is utilized. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #9]

Q8: M0150. On M0150, since Response "10" – Self Pay should be marked for a patient who pays for their medications, should Response "1" Medicare (traditional fee-for-service) be marked for a patient whose medications are expected to be paid for in part by the Medicare drug benefit?

A8: No, M0150 is limited to identifying payers to which any services provided during this home care episode, and included on the home health plan of care will be billed by your home care agency. We are retracting a Q&A released in 06/05 which extended the scope of M0150 to include reporting of "self pay" as a pay source for non-services (i.e. DME or medications) that are paid in part or full to a DME vendor or drug store for equipment or medications essential or integral to the home care episode. M0150 does not include payment for equipment, medications or supplies, and is limited to only services provided and billed for by your Medicare certified agency. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #10]

Q9: M0150. Question 11: It has come to our attention that we have been answering M0150 incorrectly. How far do we need to go back when correcting our errors?

A9: CMS regulations in the Conditions of Participation 484.20 state the encoded OASIS must be accurate. When errors are identified, follow guidance in the Medicare Conditions of Participation (CoP). The CoPs require your agency to have a policy defining how corrections are made to patient clinical records. The policy must be in compliance with any state and federal laws, and the agency must follow the policy. It should specify who is allowed to make corrections, how the corrections are to be made, and the circumstances under which such corrections can be made. The policy should clarify any differences in procedures to be followed when correcting demographic information versus correcting patient information that the clinician assessed as part of the examination of the patient. The clinical record is a legal document; consequently changes must be made only with very careful consideration. If the correction is to an OASIS item, the correction should be submitted to the state as well as corrected in the clinical record. Data entry/transmission staff should be aware that corrections involving clinical records must be made in accord with these established policies and procedures.

Regarding corrections to OASIS data already submitted to the State, information about correcting the OASIS can be found at https://www.qtso.com/hhadownload.html; scroll down the list of available resources and click on the link for HHAcorrectionpolicy.pdf. Additionally, the State Operations Manual (SOM) and the Conditions of Participation, 484.48, Clinical Record, address the issue of corrections. You can download the SOM at
http://cms.hhs.gov/manuals/Downloads/som107ap_b_hha.pdf
If the correction has an impact on billing, you need to correct to submit an accurate claim. There are no time limits on submitting correct claims beyond those contained in the Medicare Claims Processing Manual. If the correction has no billing impact, corrections should be made for at least the last 12 months of data to ensure accurate quality reporting. [CMS OCCB Q&A 10/07 #11]

Q10: CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare is always a likely secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactive the assessments altogether, since OASIS data collection/submission is not required for Private Pay patients only?

A10: M0150, Current Payer Sources, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is

admitted for home care services under a private insurer and the Medicare eligibility criteria are met, Medicare is always a likely payer and may be included in M0150. This action will ensure that OASIS data is collected in the event, Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to delete any and all assessments (e.g., SOC, transfer, ROC, discharge), clarifying in the clinical chart why the assessment is being deleted. Simply correcting M0150 and resubmitting to the state, or inactivating affected assessments will not adequately remove the patient from the data base. If the assessment is not deleted, the patient identifiable data will remain in the data base, and may inappropriately impact the agency's OBQI and OBQM reports. [Q&A added 1/08; CMS OCCB 1/08 Q&A #14] [Q&A EDITED 05/08]

Q11: CMS Q&A Category 4b Q24 states that if a patient is involved in an auto accident the M0150 response should be 1 or 2 as appropriate for that patient. Would we also pick response 11 - Other and enter auto insurance or UK - Unknown?

A11: Response 8 - refers to private health insurance. Response 11 – Other (specify) would be selected for home care services expected to be covered by auto insurance. [Q&A added 1/08; CMS OCCB 1/08 Q&A #15] [Q&A EDITED 05/08]

OASIS ITEM:

(M0175) From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**

- o 1 -Hospital
- o 2 -Rehabilitation facility
- o 3 -Skilled nursing facility
- o 4 -Other nursing home
- o 5 -Other (specify)
- o NA -Patient was not discharged from an inpatient facility **[If NA, go to *M0200*]**

DEFINITION:

Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

- Mark all that apply. For example, patient may have been discharged from both a hospital and a rehabilitation facility within the past 14 days.
- Rehabilitation facility is a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital.
- A skilled nursing facility means a Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit. Determine the following:
  1) Was the patient discharged from a Medicare-certified skilled nursing facility? If so, then:
  2) While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If so, then:
  3) Was the patient receiving skilled care under the Medicare Part A benefit up to 14 days prior to admission to home health care?

If all three of the above criteria apply, select Response 3. If any of the criteria are not satisfied, but the patient was in some type of nursing facility in the past 14 days, select Response 4.

- Other nursing home includes intermediate care facilities for the mentally retarded (ICF/MR) and nursing facilities (NF).
- If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 1), a skilled nursing bed under Medicare Part A (Response 3), or a nursing bed at a lower level of care or under (Response 4).
- If a patient was discharged from a long term care hospital, the correct response is 1.

ASSESSMENT STRATEGIES:

Information can be obtained from patient/caregiver or physician's office. When uncertain about the type of facility or whether the facility is an inpatient facility, it may be necessary to check with the facility regarding licensure/ designation. For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare. An inpatient facility discharge that occurs on the day of the assessment does fall within the 14-day period.

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Category 4B – OASIS Data Items

Q1: M0175. If the patient has outpatient surgery within the 14-day time frame described in M0175, should 1 or NA be marked?

A1: The correct response would be 'NA' for M0175 because the patient's status would have been an outpatient for this situation.

Q2: M0175. For M0175, what is the difference between response 3 (skilled nursing facility) and response 4 (other nursing home)?

A2: A skilled nursing facility (response 3) means a Medicare-certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit. Other nursing home (response 4) includes intermediate care facilities for persons with mental retardation (ICF/MR) and nursing facilities (NF). [Q&A EDITED 08/07]

Q3: M0175. M0175 refers to the inpatient facility from which the patient was discharged within the last 14 days. Please define 14 days.

A3: "During the past 14 days" refers to the two-week period immediately preceding the start of care/resumption of care (SOC/ROC) date or the first day of the new certification period at follow-up. The easiest way to determine this is to refer to a calendar. For example, if the SOC/ROC is Wednesday, August 20, look at a calendar to refer to the same day of the week two weeks ago, which in this case is August 6. For follow-up assessments, count fourteen days before the first day of the new certification period. [Q&A edited 06/05] [Q&A EDITED 08/07]

Q4: M0175. When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M0175 on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding the first day of the new certification period?

A4: When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M0175 should reflect inpatient facility discharges that have occurred during the two-week period immediately proceeding the first day of the new certification period. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #11]

Q5: M0175, We had a client who was admitted to an inpatient facility for less than 24 hours. We did not do a Transfer OASIS because the criteria for it were not met. Two days later the patient was discharged from our agency and we completed a discharge comprehensive assessment. Approximately 1 week later, the client developed a wound and was readmitted to our agency. When completing the new SOC comprehensive assessment, how do we mark M0175 regarding Inpatient Facility Discharge in the Past 14 Days?

A5: M0175, asks if the patient was discharged from an inpatient facility during the past 14 days. In your scenario, you describe a patient who was admitted and discharged from an inpatient facility during the 14 days prior to the completion of the new RFA 1 SOC comprehensive assessment. The inpatient stay would be reported in M0175. M0175 does not ask you to only report inpatient facility

stays that meet the criteria for the OASIS Transfer, i.e. it does not require that the stay in the inpatient facility is for 24 hours or greater for reasons other than diagnostic test. It simply asks whether the patient was discharged from an inpatient facility during the past 14 days. [CMS OCCB 10/07 Q&A #]

OASIS ITEM:

(M0180) Inpatient Discharge Date (most recent):

__ __ /__ __ / __ __ __ __ month day year

o UK -Unknown

DEFINITION:

Identifies the date of the most recent discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

- Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

ASSESSMENT STRATEGIES:

Obtain information from patient, caregiver, or referring physician. For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

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Category 4B – OASIS Data Items

Q1: M0180. In OASIS field M0180, if there is no date, do you just fill in zeros?

A1: As noted in the skip instructions for item M0175, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M0175 has a response of NA), M0180 and M0190 should be skipped. If the patient was discharged from an inpatient facility during the past 14 days, but the date is unknown, you should mark UK at M0180 and leave the date blank.

OASIS ITEM:

(M0190) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient facility stay within the last 14 days (no surgical, E-codes, or V-codes):

	Inpatient Facility Diagnosis	ICD-9-CM
a.	_____	(__ __ __ . __ __)
b.	_____	(__ __ __ . __ __)

DEFINITION:

Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

- Include only those diagnoses that required treatment during the inpatient stay. If a diagnosis was not treated during an inpatient admission, do not list it. (Example: The patient has a long-standing diagnosis of "osteoarthritis," but was hospitalized for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.)
- This is the diagnosis for which the patient received treatment, not necessarily the hospital admitting diagnosis (though it can be the same).
- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V-codes or E-codes. List the underlying diagnosis.

ASSESSMENT STRATEGIES:

Obtain information from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

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Category 4B – OASIS Data Items

Q1: M0190. How would additional inpatient facility diagnoses and ICD-9-CM codes be entered into M0190 since the field only allows for two sets of codes? When we include this item in our clinical forms, can we add more lines?

A1: M0190 requests the two most relevant diagnoses that were actively treated during the inpatient facility stay, not all diagnoses that the patient may have. Agencies should carefully consider whether additional information is needed and, if so, how only the most relevant information is listed in "a" and "b" of M0190. OASIS items must be reproduced in the agency clinical forms exactly as they are written. If the agency desires additional information, the most appropriate course of action may be to insert an additional clinical record item immediately following M0190. [Q&A EDITED 08/07]

Q2: M0190. It takes days (sometimes even a week) to get the discharge form from the hospital. How can we complete this item in a timely manner?

A2: Information regarding the condition(s) treated during the inpatient facility stay has great relevance for the SOC/ROC assessment and for the plan of care. The agency may instruct intake personnel to gather the information at the time of referral. Alternatively, the assessing clinician may contact the hospital discharge planner or the referring physician to obtain the information.

Q3: M0190. Can anyone other than the assessing clinician enter the ICD codes?

A3: Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the severity indices. The clinician should write-in the medical diagnosis requested in M0190, M0210, M0230/M0240, and M0245, if applicable. A coding specialist in the agency may enter the actual numeric ICD-9 codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD9-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency. [Q&A EDITED 08/07]

Q4: M0190/M0210. What is the difference between M0190 and M0210?

A4: M0190 and M0210 refer to two separate situations. M0190 relates to a patient who has been discharged from an inpatient facility within the past 14 days and reports the diagnoses for conditions that were treated during the inpatient facility stay. M0210 relates to a change in the patient's medical or treatment regimen during the same past 14 days. The diagnoses in the two items may be the same, but there is no requirement that they be identical. For a patient who was not discharged from an inpatient facility during the past 14 days, M0190 would be skipped.

OASIS ITEM:

(M0200) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?

- o 0 -No **[If No, go to *M0220;* if No at Discharge, go to *M0250*]**
- o 1 -Yes

DEFINITION:

Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an existing diagnosis within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.)

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If "No" is selected at discharge, the clinician should be directed to skip to M0250 (Therapies).

ASSESSMENT STRATEGIES:

Obtain information from patient, caregiver, or referring physician. Note that the item addresses any change in the medical or treatment regimen within the past 14 days. A physician appointment alone or a referral for home health services does NOT qualify as a medical or treatment regimen change. A treatment regimen change that occurs on the day of the assessment does fall within the 14-day period.

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Category 4B – OASIS Data Items

Q1: M0200/M0210. Please clarify M0200 - Medical or Treatment Regimen Change within past 14 days and M0210 - Medical Diagnoses (for conditions requiring the change).

A1: For M0200, identify whether any change has occurred in the patient's medical or treatment regimen in the past 14 days. Is there a new diagnosis or an exacerbation of an old diagnosis that necessitates a change in the treatment regimen? For example, has there been a medication dosage change? Are therapy services newly ordered as a treatment regimen change? Has a regimen change occurred in response to a change in patient health status? M0210 then asks what medical diagnosis has necessitated this change in regimen? Was the diuretic increased due to an exacerbation of congestive heart failure? Was the patient started on insulin due to a new diagnosis of diabetes?

Q2: M0200. Must the "new or changed diagnosis" have occurred in the last 14 days?

A2: M0200 asks about a change in the patient's medical or treatment regimen, not about a "new or changed diagnosis." It is possible that the treatment regimen change occurred because of a new or changed diagnosis, but the item only asks about the medical or treatment regimen change occurring within the past 14 days. The change may have occurred because of an exacerbation or improvement of an existing diagnosis. [Q&A EDITED 08/07]

Q3: M0200. If the patient had a physician appointment in the past 14 days, or has a referral for home care services, does that qualify as a medical/treatment regimen change?

A3: A physician appointment by itself or a referral for home health services does not qualify as a medical or treatment regimen change.

Q4: M0200. If the treatment regimen change occurred on the same day as the visit, does this qualify as within the past 14 days?

A4: A treatment regimen change occurring on the same day as the assessment visit does qualify as occurring within the past 14 days.

Q5: [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat4b, Q#40.]

Q6: M0200. I was told that an exacerbation of a disease can be considered a change in medical or treatment regimen for M0200, Medical or Treatment Regimen Change Within Past 14 Days. Is this true?

A6: The exacerbation of a disease, in and of itself, would not be considered a change in medical or treatment regimen for M0200. The changes in medication, service, or treatment that might result from a new diagnosis or the exacerbation of a disease would warrant in a "Yes" response on M0200. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #12]

Q7: M0200. If physical therapy (or any other discipline included under the home health plan of care) was ordered at Start of Care (SOC) and discontinued during the episode, does this

qualify as a service change for M0200 at the Resumption of Care (ROC) or DC OASIS data collection time points? I understand that the referral and admission to home care does not qualify as a med/tx/service change for M0200.

A7: Physical therapy (or any other discipline) ordered at SOC and then discontinued during the episode, qualifies as a service change for M0200 at the ROC or DC OASIS data collection time points. You are correct that referral and admission to home care does not "count" as a medical or treatment regimen change. This means that all home care services or treatments ordered at SOC/ROC would not "count" for M0200, but would thereafter, if there was a change.
While a treatment change occurring on the same day as the assessment visit usually qualifies as occurring within the past 14 days, the discontinuation of home care services at DC, do NOT count as a "Yes" for M0200 (If it did, all episodes would include a "Yes" on M0200 at DC.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #13]

Q8: M0200, Scenario: In the case of an unplanned discharge, how do we calculate the 14 day look back period when responding to M0200?

A8: M0200 is asking if there was a medical or treatment regimen change within the past 14 days. M0200 information in Chapter 8 states "Past 14 days encompasses the two-week period immediately preceding the start/resumption of care or the discharge date." However, in the case of an unplanned discharge, often the discharge assessment visit date is several days prior to the actual discharge date. In the case of an unplanned or unexpected discharge, the assessment data is based on the last visit made by a qualified clinician. In the case of an unplanned discharge, M0200, M0210 and M0220 should be answered based on medical or treatment changes that occurred during the two week period immediately preceding the "last qualified clinician" visit date on which the discharge assessment is based. [CMS OCCB 10/07 Q&A #]

OASIS ITEM:

(M0210) List the patient's **Medical Diagnoses** and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

	Changed Medical Regimen Diagnosis	ICD-9-CM
a.	_____	(__ __ __ . __ __)
b.	_____	(__ __ __ . __ __)
c.	_____	(__ __ __ . __ __)
d.	_____	(__ __ __ . __ __)

DEFINITION:

Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment regimen, health care services received, or medications within the past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care [or the date of the discharge visit].)

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Can be a new diagnosis or an exacerbation to an existing condition.
- No surgical codes - list the underlying diagnosis.
- No V-codes or E-codes - list the appropriate diagnosis.
- Response to this item may include the same diagnoses as M0190 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.

ASSESSMENT STRATEGIES:

Obtain diagnosis from patient, caregiver, or referring physician. The current ICD-9-CM code book should be the source for coding.

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Category 4B – OASIS Data Items

Q1: M0200/M0210. Please clarify M0200 - Medical or Treatment Regimen Change within past 14 days and M0210 - Medical Diagnoses (for conditions requiring the change).

A1: For M0200, identify whether any change has occurred in the patient's medical or treatment regimen in the past 14 days. Is there a new diagnosis or an exacerbation of an old diagnosis that necessitates a change in the treatment regimen? For example, has there been a medication dosage change? Are therapy services newly ordered as a treatment regimen change? Has a regimen change occurred in response to a change in patient health status? M0210 then asks what medical diagnosis has necessitated this change in regimen? Was the diuretic increased due to an exacerbation of congestive heart failure? Was the patient started on insulin due to a new diagnosis of diabetes?

Q2: M0210. For the medical diagnosis in the changed medication section at OASIS item M0210, does this need to be the current diagnosis we are seeing the patient for, or a diagnosis that is specific for the medication?

A2: Item M0210 identifies the diagnosis(es) causing a change to the patient's treatment regimen, health care services, or medication within the past 14 days. The ICD-9 code can be a new diagnosis or an exacerbation of an existing condition that is specific to the changed medical or treatment regimen. Also note that this item is not restricted to medications, but refers to any change in medical or treatment regimen. [Q&A EDITED 08/07]

OASIS ITEM:

(**M0220**) **Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:** If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

- o 1 -Urinary incontinence
- o 2 -Indwelling/suprapubic catheter
- o 3 -Intractable pain
- o 4 -Impaired decision-making
- o 5 -Disruptive or socially inappropriate behavior
- o 6 -Memory loss to the extent that supervision required
- o 7 -None of the above
- o NA -No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- o UK -Unknown

DEFINITION:

Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days. (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.)

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Mark “NA” if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be correct.
- All references to inpatient facility stay or facility discharge are omitted at the discharge assessment (from the home health agency).
- At discharge, omit "NA" and "UK."

ASSESSMENT STRATEGIES:

Interview patient/caregiver to obtain past health history. Additional information may be obtained from the physician. Determine any conditions existing before the inpatient facility stay or before the change in medical or treatment regimen.

OASIS ITEM

M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2) . Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.

Code each row as follows:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;
Rate the severity of the condition listed in Column 1 using the following scale:
0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row.

Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave column 4 blank in that row.

(M0230) Primary Diagnosis & (M0240) Other Diagnoses		**(M0246) Case Mix Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
	ICD-9-CM and severity rating for each condition	Complete **only if** a V code in Column 2 is reported in place of a case mix diagnosis.	Complete **only if** the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Severity Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M0230) Primary Diagnosis a.	**(V codes are allowed)** a. (__ __ __ . __ __) 0 1 2 3 4	***(V or E codes NOT allowed)*** *a.* (__ __ __ . __ __)	***(V or E codes NOT allowed)*** a. (__ __ __ . __ __)
(M0240) Other Diagnoses b.	**(V or E codes are allowed)** b. (__ __ __ __ . __ __) 0 1 2 3 4	***(V or E codes NOT allowed)*** *b.* (__ __ __ . __ __)	***(V or E codes NOT allowed)*** b. (__ __ __ . __ __)
c.	c. (__ __ __ __ . __ __) 0 1 2 3 4	*c.* (__ __ __ . __ __)	c. (__ __ __ . __ __)

(M0230) Primary Diagnosis & (M0240) Other Diagnoses		(M0246) Case Mix Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
	ICD-9-CM and severity rating for each condition	Complete **only if** a V code in Column 2 is reported in place of a case mix diagnosis.	Complete **only if** the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Severity Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
d.	d. (__ __ __ __ . __ __) 0 1 2 3 4	*d.* (__ __ __ . __ __)	d. (__ __ __ . __ __)
e.	e. (__ __ __ __ . __ __) 0 1 2 3 4	*e.* (__ __ __ . __ __)	e. (__ __ __ . __ __)
f.	f. (__ __ __ __ . __ __) 0 1 2 3 4	*f.* (__ __ __ . __ __)	f. (__ __ __ . __ __)

DEFINITION:

Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity. The primary diagnosis (M0230) should be the condition that is the chief reason for providing home care. Secondary diagnoses in M0240 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. A case-mix diagnosis is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, “other” diagnosis, or a manifestation associated with a primary or other diagnosis. Diagnoses listed under columns 3 and 4 should be documented on the patient’s Plan of Care in compliance with 42 CFR 484.18(a). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site at the following address: http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp; click on HH PPS Grouper Software and Documentation.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- V codes may be entered in row "a." of Column 2 (item M0230); V codes and E codes may be entered in the other rows in Column 2 (item M0240).
- V codes and E codes may not be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only.
- In optional Columns 3 and 4, complete only those rows in which a V code has been reported in place of a case mix diagnosis in Column 2.
- Complete Columns 1 and 2 from top to bottom, leaving any blank entries at the bottom.
- In optional Columns 3 and 4, There may be blank entries in any row. When optional code(s) are entered in Columns 3 and 4, ensure that they are placed in the row that shows the corresponding V-code.
- No surgical codes -- list the underlying diagnosis.

ASSESSMENT STRATEGIES:

M0230/240: Primary and Other Diagnoses Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician. Review current medications and other treatment approaches. Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. The current ICD-9-CM guidelines should be followed in coding these items.

Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

M0246: Case Mix Diagnoses (OPTIONAL)

Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions:

- No surgical codes -- list the underlying diagnosis.
- V codes cannot be used in case mix group assignment. If a provider reports a V code in M0230/240 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0246.
- If the case-mix diagnosis requires multiple diagnosis under ICD-9-CM coding guidelines, enter these codes in Columns 3 and 4, e.g., if the code is coded as a combination of an etiology and a manifestation code, the etiology code should be entered in Column 3 and the manifestation code should be entered in Column 4.

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Category 4B – OASIS Data Items

Q1: M0230/M0240/M0245. It is difficult to understand when an ICD-9-CM code must be entered at M0245. Where can we find help?

A1: For Clarification of OASIS items M0230, M0240, and M0245 please refer to the *OASIS User's Manual*, Attachment D to Chapter 8, at: http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. [Q&A EDITED 08/07]

Q2: M0230/M0240. During a supervisor's audit of a SOC assessment, the auditor finds a manifestation code listed as primary without the required etiology code reported. Can this be considered a technical coding "error", and can the agency follow their correction policy allowing the agency's coding expert to correct the non-adherence to multiple coding requirements mandated by the ICD-9-CM coding guidelines, without conferring with the assessing clinician?

A2: The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M0230, and ICD-9-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a diagnosis is being added. If any diagnosis is being added, in this case for manifestation coding requirements, the assessing clinician must be contacted and agree. If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a "technical" error and the coding specialist may not automatically make the correction without consulting with the assessing clinician. If after discussion of the manifestation coding situation between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor and that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC using current ICD-9-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #14]

Q3: M0230/M0240. Is it true that you can never change M0230 or M0240 from the original POC (cert) until the next certification?

A3: Guidance in Chapter 8 of the OASIS User's manual, pg. 8.42 and 8.145, states the primary diagnosis is the chief reason the agency is providing home care, the condition most related to the plan of care. Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." "In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself." M0230, Primary Diagnosis and M0240, Other Diagnoses are reported at Start of Care, Resumption of Care and Follow-up/Recertification. At each time point, after completing a comprehensive assessment of the patient and receiving input from the physician, the clinician will report the patient's current primary and secondary diagnoses. Diagnoses may change following an inpatient facility stay - the Resumption of Care and following a major change in the patient's health status - the Other Follow up. The chief reason an agency is caring for a patient may change. The focus of the care may

change. At each required time point the clinician will assess and report what is true at the time of the assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #13]

Q4: When reporting secondary codes in M0240, must codes be listed in order of their severity rating? Or according to the significance to the plan of care?

A4: This mailbox is made available specifically to support the educational needs of home health providers and stakeholders related to OASIS data collection guidelines and requirements. In order to ensure that this focused need can be maintained, only the portion of the question related to OASIS data collection and guidance will be addressed.
Chapter 8 of the OASIS User's manual shares the guidance below related to primary and secondary diagnoses as well as the severity rating:
Under Response-Specific Guidance:
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is categorized according to its severity. The primary diagnosis (M0230) should be the condition that is the chief reason for providing home care. Secondary diagnoses in M0240 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. The Medicare Home Health Diagnosis Coding document is found at http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp
Under Assessment Strategies:
Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician. Assessing severity includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past. The current ICD-9-CM guidelines should be followed in coding these items. At this time there is no OASIS guidance suggesting you must rank diagnoses by their severity rating and this mailbox focus is dedicated to OASIS guidance. You may benefit from checking with your RHHI, the Claims Processing Manual and Official ICD-9-CM Guidelines for Coding and Reporting for further guidance related to ICD-9 coding/sequencing. [Q&A added 1/08; CMS OCCB 1/08 Q&A #16] [Q&A EDITED 05/08]

Q5: If a V code is used in M0230 and a different V code in M0240 that both replace the same case mix diagnosis should you report the case mix diagnosis twice in M0246?

A5: The general OASIS data collection instruction for M0246 - Payment Diagnosis is that if a V code listed in M0230 or M0240 is reported in place of a case mix diagnosis, the agency may optionally list the appropriate case mix diagnosis in the M0246 field in the row as the corresponding V code. Current OASIS data collection guidelines are not any more specific related to directing providers to alter this general instruction in situations in which this general guideline may or may not be necessary, based on reimbursement impact. Providers should be aware that the completion of M0246 (at any and all levels) is always optional, and that ICD-9 codes provided in M0246 may, under certain but not all conditions, impact payment under the Medicare PPS. Providers are encouraged to reference official ICD-9- CM coding guidelines for appropriate coding practices, and review the details of the PPS model and associated tables for details on when and how the use of ICD-9 codes reported in M0230/M0240 & M0246 impact reimbursement. You can access PPS related

guidance from the CMS Home Health Agency Center
http://www.cms.hhs.gov/center/hha.asp
[Q&A added 1/08; CMS OCCB 1/08 Q&A #17] [Q&A EDITED 05/08]

Q6: Can ICD-9 codes that are case mix codes be placed in M0246 on any OASIS which is a Non-PPS Payer? (Example: Medicaid HMO)

A6: M0246 is an optional item and an agency is not required to complete it. When an agency chooses to complete M0246 in order to facilitate accurate payment, the general OASIS data collection instruction states "If a provider reports a V code in M0230/240 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M0246." The intention is that the case mix diagnoses that were replaced by V-Codes in M0230 and/or M0240 should be reported in M0246 to facilitate payment for any patient for whom the OASIS 1.6 data set is being used to determine an HHRG/HIPPS. M0246 is optional, and may be completed for any assessment which will be used to generate an HHRG/HIPPS code for payment, including payers other than Medicare PPS. [Q&A added 4/08; CMS OCCB 4/08 Q&A #6] [Q&A EDITED 05/08]

Q7: It is challenging for our agency to ensure that all assessing clinicians know the list of case mix diagnoses, and we want to insure they are coding based on appropriate guidelines and not focused on coding to increase reimbursement. As such, our policy is that whenever a V code is listed in M0230 or M0240, the assessing clinician will list in M0246, on the same line, the applicable numeric code reflecting the underlying condition related to the V code. In some cases, the numeric codes listed are case mix diagnoses and criteria are met for payment to be favorably increased. In other cases, the numeric codes listed in M0246 do not increase payment, and in fact may not even be from the case mix diagnoses list. Is this an acceptable practice?

A7: If a numeric code is listed in M0246, it will only contribute to payment under PPS if it meets required conditions (e.g., is a case mix diagnosis, is listed in the proper sequence, replaces an eligible V code). A numeric code listed in M0246 might not affect payment because it is not a case mix diagnosis, or because it is a case mix diagnosis but does not meet all the conditions required to affect payment-- e.g., if the assessment does not include other responses (such as ADL dependence) that are needed for the diagnosis to earn points; or the code listed does not replace an eligible V code. If required conditions are not met, the code is ignored by the payment grouper. Listing an unnecessary code in M0246 is not a noncompliant or unacceptable practice; just unnecessary, as far as payment is concerned. However, in addition to potential payment impact, codes in M0246 also have a potential risk adjustment impact. The guidance from Chapter 8 for completing M0246 states "If a V code reported in any row in column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis in the same row in Column 3". However, a code reported in M0246 will be appropriately available and considered for risk adjustment even if it does not impact payment. [Q&A added 4/08; CMS OCCB 4/08 Q&A #7] [Q&A EDITED 05/08]

Q8: I understand from the CMS OASIS OCCB 01/07 Q&A #17 that a case mix diagnosis may be listed at multiple levels in M0246. What is the rationale for repeating a case mix diagnosis more than once? Is there a payment implication? Is there a risk adjustment implication?

A8: In some, less complex coding scenarios, the repeating of the same case mix diagnosis in M0246 (or listing a case mix diagnosis that is also reported in M0230 or M0240) may not have a payment impact. In more complex coding situations, repeating the code may have a payment impact, although the complexity of the scoring process may not make this readily apparent. For instance, when a V code replaces a condition that must be reported using mandatory multiple coding, and both the etiology and manifestation codes are case mix diagnoses from different

Diagnostic Groups, PPS payment model criteria will determine which of the two codes will bring the most points, and it will contribute to payment, and the other will not. This means that the case mix diagnosis not used may be eligible to contribute toward payment if listed (repeated) at another level. It may not be readily apparent to the assessing clinician which of the case mix codes pair (the etiology or the manifestation code) was not selected for payment impact, and if that non-scoring case mix code meets conditions to be repeated at another level, and is not repeated, it will not be available for potential reimbursement increase.

Because of the complexity of the various opportunities to demonstrate increased patient acuity and favorably impact reimbursement through diagnosis reporting, it may be in the agency's best interest to enter case mix diagnoses that are replaced by V codes whenever this occurs, even if the listed code is duplicated, to minimize the chance of missing opportunities to gain eligible points toward payment.

Eligible diagnosis codes from M0246 are considered for risk adjustment calculation, but are only considered once. Therefore duplicating or repeating a case mix diagnosis will not impact risk adjustment. [Q&A added 4/08; CMS OCCB 4/08 Q&A #8] [Q&A EDITED 05/08]

OASIS ITEM:

(M0250) Therapies the patient receives at home: **(Mark all that apply.)**

- o 1 -Intravenous or infusion therapy (excludes TPN)
- o 2 -Parenteral nutrition (TPN or lipids)
- o 3 -Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- o 4 -None of the above

DEFINITION:

Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• This item addresses only therapies administered at home. Exclude similar therapies administered in outpatient facilities.

• If the patient will receive such therapy as a result of this assessment (e.g., the IV will be started at this visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.

• Select Response 1 if a patient receives intermittent medications or fluids via an IV line (e.g., heparin or saline flush). If IV catheter is present but not active (e.g., site is observed only or dressing changes are provided), do not mark Response 1.

• Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump.

• Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain), but those parameters are not met on the day of the assessment.

• Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does not apply. A flush of a feeding tube does not provide nutrition.

ASSESSMENT STRATEGIES:

Determine from patient/caregiver interview, nutritional assessment, review of past health history, and referral orders. Assessment of hydration status or nutritional status may result in an order for such therapy (therapies).

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Category 4B – OASIS Data Items

Q1: M0250. Does M0250 refer to the therapies the patient is receiving when the staff member walks in to do the OASIS assessment? What if the patient is known to need enteral feedings and is scheduled for setup post-OASIS assessment? Please clarify.

A1: M0250 refers to therapies the patient is receiving during the day of the assessment or which the patient is ordered to receive as a result of the assessment visit. For example, if the assessment reveals the existence of dehydration, and the clinician's communication results in an order for IV therapy, response 1 would be marked. [Q&A EDITED 08/07]

Q2: M0250. Does a central line (OR subcutaneous infusion OR epidural infusion OR intrathecal infusion OR an insulin pump OR home dialysis, including peritoneal dialysis) "count" in responding to M0250?

A2: Only one question must be answered to determine whether these examples "count" as IV or infusion therapy -- is the patient receiving such therapy at home? If the patient were receiving such therapy at home, then response 1 for M0250 would be appropriate. If the infusion therapy is administered in the physician's office or outpatient center or dialysis center, and no infusion or flush is occurring in the home, response 4 would be marked. [Q&A edited 06/05] [Q&A EDITED 08/07]

Q3: M0250. Does an IM or SQ injection given over a 10-minute period "count" as an infusion?

A3: No, this injection does not "count" as infusion therapy.

Q4: M0250. If the patient refuses tube feedings, does this "count" as enteral nutrition?

A4: If the patient's refusal has resulted in the patient not receiving enteral nutrition on the day of the assessment, response 3 would not be appropriate at the time of the assessment. The refusal of the tube feedings would be noted in the clinical record. Flushing the feeding tube does not provide nutrition. [Q&A EDITED 08/07]

Q5: M0250. If the caregiver provides the enteral nutrition independently, should response 3 be marked, or does the HHA need to provide the care?

A5: M0250 simply asks about therapies the patient is receiving at home. Since this patient is receiving enteral nutrition at home, response 3 should be marked.

Q6: M0250. Do therapies provided in the home have to be documented in the clinical record?

A6: It seems clear that any of the therapies identified in M0250 (IV/infusion therapy, parenteral nutrition, enteral nutrition) would be acknowledged in the comprehensive assessment and be noted in the plan of care. Even if the family or caregiver manages the therapies completely independently, the clinician is likely to evaluate the patient's nutritional or hydration status, signs of

infection, etc. It is difficult to conceive of a situation where the answer to this question would be "no."

Q7: M0250. Does M0250 relate to other OASIS items?

A7: Note the subsequent items of M0810 (Patient Management of Equipment) and M0820 (Caregiver Management of Equipment), which address IV/infusion therapy and enteral/parenteral equipment or supplies.

Q8: M0250. If the discharge visit includes discontinuing IV or infusion therapy, should the OASIS item (M0250) reflect the presence of these services on the discharge assessment?

A8: Yes, if the IV is being discontinued the day of the assessment visit, then those respective services can be marked as "present" at the assessment. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #3]

Q9: M0250. A patient has an order on admission for an IV infusion to be given prn, if specific parameters are present. None of the parameters exist at SOC, and no IV line is inserted. What is the appropriate response to M0250?

A9: If the patient will receive an IV infusion as a result of the SOC assessment (i.e., the predetermined parameters are met), then response 1 is appropriate. If the parameters are not met at the SOC assessment, then response 1 does NOT apply. [Q&A added 06/05] [Q&A EDITED 08/07]

Q10: M0250. When a patient has a G-tube (NG-tube, J-tube, and PEG-tube) and it is only utilized for medication administration, do you mark Response 3, Enteral nutrition for M0250, Therapies?

A10: No, M0250 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #15]

Q11: M0250. When a patient has a feeding tube and it is only utilized for the administration of water for hydration (continuous or intermittent), do you mark Response 3, Enteral nutrition for M0250, Therapies?

A11: No, M0250 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #16]

Q12: M0250. I understand that if the patient is receiving infusion therapy in the home and the family or caregiver manages it completely that we should report the infusion therapy on M0250. Is this also true when the patient is receiving infusion therapy in the home from another provider?

A12: Only one question must be answered to determine whether the infusion "counts" as IV or infusion therapy – "Is the patient receiving such therapy at home?" regardless of who is managing it. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #17]

Q13: M0250. A patient has a Hickman catheter and is receiving TPN over 12 hours. At the beginning of the infusion, the line is flushed with saline and at the end of the infusion, it is flushed with saline and Heparin. For M0250, do you mark both 1 and 2?

A13: When the patient is receiving intermittent parenteral therapy at home and requires a pre- and post-infusion flush, it is not appropriate to mark Response 1, Intravenous or infusion therapy (excludes TPN), in addition to Response 2, Parenteral nutrition (TPN or lipids). The flushing of the line for intermittent parenteral therapy is considered a component of the parenteral therapy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #18]

Q14: M0250. If a patient's appetite is poor and he/she has a g-tube and the physician orders Ensure prn through the g-tube? Does this count as enteral nutrition for this item?"

A14: If a PRN order exists and the patient meets the parameters for administration of the feeding based on the findings from the comprehensive assessment, or has met such parameters and/or received enteral nutrition at home in the past 24 hours, the assessing clinician would mark Response 3. The clinician could not mark response 3 automatically when a PRN order exists at SOC because it is unknown if the patient will ever receive the enteral nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #14]

Q15: M0250. We have been admitting patients status post lumpectomy for breast cancer. After the surgery, they are discharged with an eclipse (bulb) that has Marcaine or Lidocaine that infuses pain medication into the wound bed. After 48 hours the bulb can be removed. If the patient still has this bulb on at start of care, should Response 1 be marked for M0250?

A15: When a patient is receiving an infusion at home, M0250 should be marked with Response 1Intravenous or infusion therapy. If the patient you describe is receiving a local anesthetic via an infusion device while in the home, M0250 would be marked "1" at SOC. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #5]

Q16: M0250, For M0250, is Pedialyte, an electrolyte based drink, considered enteral nutrition?

A16: M0250, Response 3 is selected when the patient receives enteral nutrition while in the home. Oral electrolyte maintenance solutions, such as Pedialyte, are administered to prevent dehydration and are not designed to act as nutrition. Response 3 would not be selected unless other forms of enteral nutrition are being administered in the home. [CMS OCCB 10/07 Q&A #]

Q17: Is medication administered via the transdermal route considered an infusion (Response 1) for M0250, Therapies at Home?

A17: A transdermal medication is absorbed through the skin and should not be considered an infusion for M0250, Therapies the patient receives at home. M0250 Response 1 IV or infusions involve a therapeutic drug or solution that is administered via an infusion device, including a needle flush, implanted or external pump, or other infusion device, such as an eclipse bulb.

Q18: We would like a clarification related to patients who draw up medication and refill an implanted pump (such as an epidural) themselves at home. For M0250 the response would

be #1 as per the OASIS Manual. For M0800 would this response be 0. If a company comes in to the home and fills the pump at home, how would we respond to M0250 and M0800? If the patient goes to a physician's office to have it filled, how would these questions be answered?

A18: If the epidural infusion is occurring in the home, it is included in M0250, regardless of who is managing the infusion.

When a patient is receiving an epidural infusion, the infusion is not considered for M0800 regardless of whether it is filled and/or infusing in the home or the office. M0800 Injectable Medications includes medications that either the patient or medical staff directly inject via needle and syringe subcutaneously or intramuscularly. Medications where the route of administration is infusion (e.g., sub-q, epidural, or IV) are not considered injectable medications, even if the medication is injected into the pump, chamber, or other external or implanted access/infusion device via a needle/syringe by the patient. [Q&A added 4/08; CMS OCCB 4/08 Q&A #14] [Q&A EDITED 05/08]

OASIS ITEM:

(M0260) Overall Prognosis: BEST description of patient's overall prognosis for recovery from this episode of illness.

- 0 -Poor: little or no recovery is expected and/or further decline is imminent
- 1 -Good/Fair: partial to full recovery is expected
- UK -Unknown

DEFINITION:

Identifies the patient's expected overall prognosis for recovery at the start of this home care episode.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

• Note that "Good" and "Fair" are both included in Response 1.

ASSESSMENT STRATEGIES:

Interview for past health history and observe current health status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding overall prognosis.

Category 4B – OASIS Data Items

Q1: M0260. Does Overall Prognosis, M0260, refer to the prognosis of the primary diagnosis or the overall prognosis? For instance, if a patient had a primary diagnosis of fractured hip from which he would recover and a secondary diagnosis of cancer for which gradual deterioration was expected, would the prognosis be "good" because it refers only to the hip fracture?

A1: The focus of M0260 is the overall prognosis for recovery from this episode of illness (for which the home care is being provided). In the example, if the patient's recovery from the hip fracture is complicated by metastasis of the cancer to the bone, then the patient's condition might be noted as response 0-Poor, according to the clinician's assessment. Patient prognosis is also required for the Plan of Treatment.

OASIS ITEM:

(M0270) Rehabilitative Prognosis: BEST description of patient's prognosis for functional status.

- ☐ 0 - Guarded: minimal improvement in functional status is expected; decline is possible
- ☐ 1 - Good: marked improvement in functional status is expected
- ☐ UK - Unknown

DEFINITION:

Identifies the patient's expected prognosis for functional status improvement at the start of this episode of home care.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Interview for past health history and observe the current functional status. Consider diagnosis and referring physician's expectations for this patient. Based on information received from these data sources, make informed judgment regarding rehabilitative prognosis.

OASIS ITEM:

(M0280) Life Expectancy: (Physician documentation is not required.)

- o 0 -Life expectancy is greater than 6 months
- o 1 -Life expectancy is 6 months or fewer

DEFINITION:

Identifies those patients for whom life expectancy is fewer than six months.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• A “Do Not Resuscitate” order does not need to be in place.

ASSESSMENT STRATEGIES:

Interview the patient/caregiver to obtain past health history. Observe current health status. Consider medical diagnosis and referring physician’s expectations for patient. If the patient is frail and highly dependent on others, ask the family whether the physician has informed them about life expectancy. Based on information received from these data sources, make informed judgment regarding life expectancy.

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Category 4B – OASIS Data Items

Q1: M0280. Life Expectancy is assessed at the Start of Care, Resumption of Care, and at Discharge. We don't have the opportunity to change this response if there is a change in the patient and there is no intervening inpatient stay. What should we do?

A1: The reduced burden OASIS did remove the opportunity to update this item with another assessment (RFA4/5). Please document any changes in your patient in the patient's clinical record when there is a change in his/her status.

OASIS ITEM:

(M0290) High Risk Factors characterizing this patient: **(Mark all that apply.)**

- o 1 -Heavy smoking
- o 2 -Obesity
- o 3 -Alcohol dependency
- o 4 -Drug dependency
- o 5 -None of the above
- o UK -Unknown * * At discharge, omit "UK - Unknown."

DEFINITION:

Identifies specific factors that may exert a high impact on the patient's health status and ability to recover from this illness.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Utilize agency assessment guidelines and informed professional decision-making. Consider amount and length of exposure when responding (e.g., smoking one cigarette a month may not be considered a high risk factor). Specific definitions for each of these factors do not exist.

ASSESSMENT STRATEGIES:

Interview patient/caregiver for past health history. Observe environment and current health status.

OASIS ITEM:

(M0300) Current Residence:

- o 1 -Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
- o 2 -Family member's residence
- o 3 -Boarding home or rented room
- o 4 -Board and care or assisted living facility
- o 5 -Other (specify)

DEFINITION:

Identifies where the patient is residing during the current home care episode (e.g., where the patient is receiving care).

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Response 1: Dwelling considered to be the patient's own.

• Response 2: Dwelling considered to belong to family member. Patient may be a temporary or permanent resident.

• Response 3: Room rented in a larger dwelling. Patient's room may be the only one rented or one of many. No specific health-related services or supervision are provided, though meals can be included.

• Response 4: Some care or health-related services are provided in conjunction with living quarters.

ASSESSMENT STRATEGIES:

Observe the environment in which the visit is being conducted. Interview the patient/caregiver regarding others living in the residence, their relationship to the patient, and any services being provided.

OASIS ITEM:

(M0340) Patient Lives With: (Mark all that apply.)

- o 1 -Lives alone
- o 2 -With spouse or significant other
- o 3 -With other family member
- o 4 -With a friend
- o 5 -With paid help (other than home care agency staff)
- o 6 -With other than above

DEFINITION:

Identifies whomever the patient is living with at this time, even if the arrangement is temporary.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• "Other family member" could include in-laws, children, cousins, etc.

• "Paid help" would include help provided under a special program (e.g., Medicaid), even though the patient may not be directly paying for this help.

• Intermittent (e.g., a few hours each day, one to two days a week, etc.) paid help is not considered as help the patient "lives with."

ASSESSMENT STRATEGIES:

This is information all agencies need to know in planning care and services. Try to incorporate this question into the conversation, so the patient does not feel an investigation is being conducted.

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Category 4B – OASIS Data Items

Q1: M0340. How should we respond to M0340 for patients living in an Assisted Living Facility (ALF)?

A1: Rules for licensing Assisted Living Facilities vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. This item simply asks who the patient lives with, not about the type of assistance that the patient receives. For example: a patient living in his/her own room would be response #1, Lives alone, while a patient sharing a room or studio apartment with someone would be response #2 (With spouse or significant other) or #4 (With a friend).

Q2: M0340. My patient lives alone Monday through Friday but has hired help to stay with her on the weekend; how should I respond to this item?

A2: Weekend help would be considered "intermittent' help according to the item-by-item tips found in Chapter 8 of the *OASIS User's Manual*. Therefore, the correct response in this situation would be "1 - Lives alone."

Q3: M0340. What if paid help lives with the patient Monday through Friday, would we still score, in this section, 1-lives alone? My understanding is that this section is not asking about what kind of help the patient receives.

A3: You are describing paid help that lives with the patient intermittently, Monday through Friday. Intermittent (e.g., a few hours each day, one or two days a week, etc.) paid help is not classified as help the patient "lives with." The correct response for M0340, in this case, would be 1-Lives alone.

M0340 is asking with whom the patient is living with at the time of the assessment, even if the arrangement is temporary. Subsequent items will capture information about the primary caregiver and the type and quantity of assistance s/he provides. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #15]

Q4: M0340 & M0350. What are the correct responses for M0340 and M0350 in the situation where family members that live outside the home are staying around the clock with a patient (caregivers are taking turns with each other)? If the patient has 24 hour supervision from people outside the home, is the patient living alone?

A4: Chapter 8, Page 8.51 of the OASIS Implementation Manual (www.cms.hhs.gov/OASIS/05_UserManual.asp) instructs that M0340 should identify whomever the patient is living with at the time of the assessment, even if the arrangement is temporary. It does not simply ask if the patient has 24 hour companionship or supervision, but who the patient lives with.

In situations where multiple caregivers/family members stay with the patient for a number of hours each day, if each of the caregivers comes and goes to their own residences outside of the patient's home, then they do not live with the patient, even if the cumulative "coverage" equates to 24 hour supervision/companionship. The patient is living alone and M0340 should be reported as response 1 - Lives alone. These caregivers should be considered when reporting assisting persons for M0350 (unless they are home care agency staff), and response 1 - relatives, friends or neighbors

living outside the home, should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #16]

OASIS ITEM:

(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.)

- o 1 -Relatives, friends, or neighbors living outside the home
- o 2 -Person residing in the home (EXCLUDING paid help)
- o 3 -Paid help
- o 4 -None of the above **[If None of the above, go to *M0390*]**
- o UK -Unknown **[If Unknown, go to *M0390*]**

DEFINITION:

Identifies the individuals who provide assistance to the patient (EXCLUDING the home care agency).

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Response 3 – Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment that provides assistance to the patient would be classified as paid help. A patient living in an assisted living facility receives assistance from paid help.

• If patient does not receive assistance from others, mark Response 4 – None of the above.

• If "None of the above" is selected at discharge, clinician should be directed to skip to M0410.

• At discharge, change M0390 to M0410.

• At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

If the patient mentions a friend or relative helping or coming to visit, interview to find out more about who helps patient, how often, what helpers do, etc. (applies to M0360, M0370, M0380). In obtaining the health history, interview to determine whether ADL/IADL assistance is needed. If it is, request information on whether patient receives such assistance and from whom.

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Category 4B – OASIS Data Items

Q1: M0350. How should we respond to M0350 for patients living in an Assisted Living Facility (ALF)?

A1: Rules for licensing Assisted Living Facilities (ALFs) vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. Most patients in an ALF are receiving paid help, at least (#3 under M0350), although they may also be receiving help from others listed. Refer to the explanation for this item in the *OASIS User's Manual*, Chapter 8, available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp . [Q&A EDITED 08/07]

Q2: M0350. Is Meals-on-Wheels considered assistance for M0350?

A2: M0350 is asking the clinician to identify assisting person(s) other than home care agency staff. Response 3, paid help, includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family or a specific program. Meals-on-Wheels is a community-based service that assists the homebound by delivering meals and would be included in responding to M0350. [Q&A added 06/05; Previously CMS OCCB 03/05 Q #3]

Q3: M0340 & M0350. What are the correct responses for M0340 and M0350 in the situation where family members that live outside the home are staying around the clock with a patient (caregivers are taking turns with each other)? If the patient has 24 hour supervision from people outside the home, is the patient living alone?

A3: Chapter 8, Page 8.51 of the OASIS Implementation Manual (www.cms.hhs.gov/OASIS/05_UserManual.asp) instructs that M0340 should identify whomever the patient is living with at the time of the assessment, even if the arrangement is temporary. It does not simply ask if the patient has 24 hour companionship or supervision, but who the patient lives with. In situations where multiple caregivers/family members stay with the patient for a number of hours each day, if each of the caregivers comes and goes to their own residences outside of the patient's home, then they do not live with the patient, even if the cumulative "coverage" equates to 24 hour supervision/companionship. The patient is living alone and M0340 should be reported as response 1 - Lives alone. These caregivers should be considered when reporting assisting persons for M0350 (unless they are home care agency staff), and response 1 - relatives, friends or neighbors living outside the home, should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #16]

Q4: M0350. Guidance related to M0350 Assisting Persons Other than Home Care Agency Staff suggests that we are to consider using response #3 when a patient receives Meals-on-Wheels. In some of our rural areas the individuals who deliver the meals are volunteers. Since they are volunteers, it seems that *"Response 3 – Paid help"*, would be inappropriate. Would *"Response 1 – Relatives, friends, or neighbors living outside the home"* be more appropriate since in this situation the one who delivers the meal could very well be a neighbor?

A4: While the actual individual who delivers the meals may be volunteering as a community service, if the patient (or family or non-agency community program) is providing funding for the

Meals-on-Wheels service, or a similar community organization, to deliver meals, *"Response 3 - Paid help"* would be appropriate for M0350. If a neighbor is providing meals to the patient and is not working on behalf of a service organization that is reimbursed by the patient or any entity, then the appropriate response would be *"1-Relatives, friends, or neighbors living outside the home"*. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #4]

OASIS ITEM:

(M0360) **Primary Caregiver** taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):

- o 0 -No one person **[If No one person, go to *M0390*]**
- o 1 -Spouse or significant other
- o 2 -Daughter or son
- o 3 -Other family member
- o 4 -Friend or neighbor or community or church member
- o 5 -Paid help
- o UK -Unknown **[If Unknown, go to *M0390*]**

DEFINITION:

Identifies the person who is "in charge" of providing and coordinating the patient's care. A case manager hired to oversee care, but who does not provide any assistance is not considered the primary caregiver. This person may employ others to provide direct assistance, in which case "paid help" is considered the primary caregiver.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If one person assumes lead responsibility for managing care, but another provides most frequent assistance, assess further to determine if one should be designated as primary caregiver or if Response 0 – No one person, is most appropriate.

• Response 5 – Paid help includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family, or a specific program (e.g., a non-agency community program). An agency other than the home care agency doing the assessment who provides assistance to the patient would be classified as paid help.

• If the primary caregiver is the patient himself (or herself), mark Response 0 - No one person.

• If "No one person" is selected at discharge, clinician should be instructed to go to M0410.

• At discharge, change M0390 to M0410.

• At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

From M0350, it is known that the patient receives assistance. Interview to determine whom the patient considers to be the primary caregiver. For example, ask, "Of the people who help you, is there one person who is 'in charge' of making sure things get done?" "Who would you call if you needed help or assistance?"

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Category 4B – OASIS Data Items

Q1: M0360. How should we respond to OASIS item M0360 for patients living in an Assisted Living Facility (ALF)?

A1: Rules for licensing ALFs vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. The clinician making the assessment will need to determine who the primary caregiver is, and mark the appropriate response under M0360 and continue through the remaining items pertaining to the assistance provided by the primary caregiver. Refer to the explanations for these items in the *OASIS User's Manual*, Chapter 8, available at http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp [Q&A EDITED 08/07].

Q2: M0360. How should the item be answered if one person takes the lead responsibility, but another individual helps out most frequently?

A2: The clinician should assess further to determine whether one of these individuals should be designated as the primary caregiver or whether response 0 (No one person) is the most appropriate description of the situation.

OASIS ITEM:

(M0370) How Often does the patient receive assistance from the primary caregiver?

- o 1 -Several times during day and night
- o 2 -Several times during day
- o 3 -Once daily
- o 4 -Three or more times per week
- o 5 -One to two times per week
- o 6 -Less often than weekly
- o UK -Unknown

DEFINITION:

Identifies the frequency of the help provided by the primary caregiver (identified in M0360).

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Responses are arranged in order of most to least assistance received from primary caregiver.

• This item is skipped if no primary caregiver.

• At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

Ask, in various ways, how often the primary caregiver provides various types of assistance (e.g., “How often does your daughter come by? Does she go shopping for you every week? When she is here, does she do the laundry?”). As you proceed through the assessment (particularly the ADLs and IADLs), several opportunities arise to learn details of the help the patient receives.

OASIS ITEM:

(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)

- o 1 -ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- o 2 -IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- o 3 -Environmental support (housing, home maintenance)
- o 4 -Psychosocial support (socialization, companionship, recreation)
- o 5 -Advocates or facilitates patient's participation in appropriate medical care
- o 6 -Financial agent, power of attorney, or conservator of finance
- o 7 -Health care agent, conservator of person, or medical power of attorney
- o UK -Unknown

DEFINITION:

Identifies categories of assistance provided by the primary caregiver (identified in M0360).

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Response 3: Includes home repair and upkeep, mowing lawn, shoveling snow, and painting.

• Response 4: Includes frequent visits or phone calls, going with patient for outings, church services, other events.

• Response 5: Takes patient to medical appointments, follows up with filling prescriptions or making subsequent appointments, etc.

• Responses 6 and 7: Legal arrangements that exist for finances or health care.

• At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

Interview questions about types of assistance are likely to produce answers that relate to ADLs and IADLs. More specific questions need to address other aspects of assistance. At start of care, discussion of advance directives can provide information about existing legal arrangements for decision-making.

OASIS ITEM:

(M0390) **Vision** with corrective lenses if the patient usually wears them:

- o 0 -Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- o 1 -Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- o 2 -Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

DEFINITION:

Identifies the patient's ability to see and visually manage (function) within his/her environment, wearing corrective lenses if these are usually worn.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

• A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.

• Reading glasses (including "grocery store" reading glasses) are considered to be corrective lenses.

• "Nonresponsive" means that the patient is not able to respond.

ASSESSMENT STRATEGIES:

In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.

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Category 4B – OASIS Data Items

Q1: [Q&A DELETED 08/07; Duplicative of Chapter 8, OASIS User's Manual]

Q2: M0390. How is vision evaluated for the patient who is too disoriented and cognitively impaired for the clinician to assess?

A2: A caregiver may be able to assist by demonstrating the patient's response to an object that is familiar to him/her. Alternatively, this could be a situation where the patient is not able to respond, thus is nonresponsive (response 2).

Q3: M0390. Does information on vision documented in OASIS have to be backed up with documentation elsewhere in the patient's record?

A3: A patient who has partially or severely impaired vision (responses 1 or 2) is likely to require adaptations to the care plan as a result of these limitations. Therefore, it is likely that the vision impairments would be included in additional assessment data or as rationale for care plan interventions.

Q4: M0390, If a patient has a physical deficit, such as a neck injury, limiting his range of motion, which affects his field of vision and ability to see obstacles in his path, how is M0390, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected.

A4: When selecting the correct response for M0390, Vision, the clinician is assessing the patient's functional vision, not conducting a formal vision screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical deficits or impairments that limit the patient's ability to use their existing vision in a functional way would be considered. If a patient sustained an injury that limits neck movement, the patient may not be able to see obstacles in their path. A patient who has sustained a facial injury may have orbital swelling that makes it impossible for them to see and they must locate objects by hearing or touching them. Conversely, it is possible for a patient to be blind in one eye (technically not "normal vision"), but still be appropriately scored a "0" on M0390 if with the patient's existing vision, they are able to see adequately in most situations and can see medication labels or newsprint. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #6]

Q5: M0390. Our patient has dementia and is unable to answer questions related to his vision appropriately or read a medication bottle out loud. He has no obvious visual problems as outlined in M0390 response 1 or 2. How does a clinician correctly answer this question given this level of verbal impairment?

A5: When a patient is cognitively impaired, the clinician will need to observe the patient functioning within their environment and assess their ability to see functionally. Does it appear the patient can see adequately in most situations? Can they see eating and grooming utensils? Do they appear to see the buttons on their shirt/blouse? If so, the patient would be reported as a *"0-normal vision"* even though the constraints of the dementia may not allow the patient to communicate whether they can see newsprint or medication labels. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #5]

OASIS ITEM:

(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them):

- o 0 -No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
- o 1 -With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- o 2 -Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- o 3 -Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, and additional time.
- o 4 -Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.

DEFINITION:

Identifies the patient's ability to hear and to understand spoken language, in the patient's primary language. Hearing is evaluated with the patient wearing aids if he/she usually uses them.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS:

• "Nonresponsive" means that the patient is not able to respond.

ASSESSMENT STRATEGIES:

Interaction with the patient during the assessment process provides information to answer this item. Be alert to what is required to adequately communicate with the patient. If he/she uses a hearing appliance, be sure that it is in place, has a battery, and is turned on. A patient whose primary language differs from the clinician's requires additional evaluation. Can a family member or friend interpret? Does the agency provide an interpreter? Is another clinician (who speaks the patient's primary language) available? If an interpreter provides assistance, visit clinical documentation should note the assistance of this individual.

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Category 4B – OASIS Data Items

Q1: M0400. Our agency would like clarification concerning M0400 - Hearing and Ability to Understand Spoken language in patient's own language. If a patient speaks Spanish and there is an interpreter, it is difficult to ascertain the level of complexity of interpreted instructions. How are we to answer this?

A1: You will need to ask the interpreter to help you determine at what level the patient is responding. Responses to 'No observable impairment' (0) and 'Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive' (4) should be relatively simple to determine. To determine the difference between levels 1, 2 or 3, you can interact with the interpreter to determine with what difficulty the patient is responding. Inasmuch as the assessment includes assistance from an interpreter, your clinical documentation of the visit should indicate the presence of an interpreter who assists with communication between clinician and patient.

Q2: M0400. Is it correct that both auditory and receptive language functions are included in responding to this item? Therefore a deaf patient who processes spoken language effectively using lip reading strategies is scored at response level 4 (Unable to hear and understand) because the item measures the combination of BOTH hearing and comprehension?

A2: Yes, M0400 does include assessment of both hearing AND understanding spoken language. A patient unable to hear (even with the use of hearing aids if the patient usually uses them) would be scored at response level 4. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #4]

Q3: M0400, My patient's primary language is German, but he does speak English well enough for us to generally communicate without the use of an interpreter. Often I need to repeat my request, or reword my statements, but he eventually adequately understands what I'm asking or saying. When scoring M0400 Hearing and Comprehension of Spoken Language, I marked response "2" based on my assessment, but I wonder if the patient's hearing/comprehension would be better (i.e., a Response "0" or "1") if he were being spoken to in German, his primary language. Do I have to assess the patient with an interpreter in order to score M0400 in the patient's primary language, even if I feel communication is generally adequate to allow evaluation of the patient's healthcare needs and provision of care outlined in the Plan of Care?

A3: M0400 is an evaluation of the patient's ability to hear and understand verbal (spoken) language in the patient's primary language. If a patient is able to communicate in more than one language, then this item can be evaluated in any language in which the patient is fluent. If however, as you suggest, your patient's ability to hear and understand is likely not as functional in a secondary language, you should make efforts necessary to access an interpreter to determine the patient's ability to hear and comprehend in the patient's primary language. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #19]

OASIS ITEM:

(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language):

- o 0 -Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- o 1 -Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- o 2 -Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- o 3 -Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- o 4 -Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- o 5 -Patient nonresponsive or unable to speak.

DEFINITION:

Identifies the patient's ability to communicate verbally (by mouth) in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• "Nonresponsive" means that the patient is not able to respond.

• Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?

• Augmented speech through the use of esophageal speech or an electrolarynx is considered oral/verbal expression of language.

• Select Response 5 for a patient who communicates entirely by sign language or writing or is unable to speak.

ASSESSMENT STRATEGIES:

Interaction with the patient during the assessment process provides information to answer this item. Patient responses to interview questions are evaluated to determine speaking ability.

Category 4B – OASIS Data Items

Q1: M0410, How do I respond to this item if the patient uses sign language? What about a patient who communicates by writing?

A1: This item addresses the patient's ability to speak and orally (verbally) express himself/herself, not general communication ability. If the patient depends entirely on sign language or writing and is unable to speak, response 5 applies. The clinician would want to document the patient's general communication ability in another location in the clinical record, as this is important for care provision.

Q2: M0410, Can this item be answered if a patient is trained in esophageal speaking or uses an electrolarynx?

A2: Augmented speech (through the use of esophageal speech or an electrolarynx) is considered oral/verbal expression of language.

OASIS ITEM:

(M0420) Frequency of Pain interfering with patient's activity or movement:

- 0 -Patient has no pain or pain does not interfere with activity or movement
- 1 -Less often than daily
- 2 -Daily, but not constantly
- 3 -All of the time

DEFINITION:

Identifies frequency with which pain interferes with patient's activities, with treatment if prescribed.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Responses are arranged in order of least to most interference with activity or movement.

• Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete.

ASSESSMENT STRATEGIES:

When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities, e.g., the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk. Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales. The patient's treatment for pain (whether pharmacologic or nonpharmacologic treatment) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

Category 4B – OASIS Data Items

Q1: M0420, How can you assess if pain is interfering with activity or movement in a nonverbal patient? A nonresponsive patient?

A1: Nonverbal or nonresponsive patients experience pain, and careful observation establishes its presence and affect on activity or movement. The clinician should observe facial expression (frowning, gritting teeth), note changes in pulse rate, respiratory rate, perspiration, pallor, pupil size, or irritability, or signs that activity is being affected by pain (e.g., limping, guarding). [Q&A EDITED 08/07]

Q2: M0420, For pain to "interfere," does it have to prevent that activity from occurring? Or just alter or affect the frequency or method with which the patient carries out the activity?

A2: For pain to interfere with activity, it does not have to totally prevent the activity. Examples of how pain can interfere with activity without preventing it include: if pain causes the activity to take longer to complete, results in the activity being performed less often than otherwise desired by the patient, or requires the patient to have additional assistance. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #5]

Q3: M0420, If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity?

A3: If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management and should not, in and of itself, be considered as an "interference" to the patient's activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considers as "affected" or "interfered with" by pain, and the frequency of such interference should be assessed when responding to M0420. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #6]

Q4: M0420, Would a patient who restricts his/her activity (i.e., doesn't climb stairs, limits walking distances) in order to be pain-free thus be considered to have pain interfering with activity? And if so, would the clinician respond to M0420 based on the frequency that the patient limits or restricts their activity in order to remain pain-free?

A4: Yes, a patient who restricts his/her activity to be pain-free does indeed have pain interfering with activity. Since M0420 reports the frequency that pain interferes with activity (not the presence of pain itself), then M0420 should be scored to reflect the frequency that the patient's activities are affected or limited by pain, even if the patient is pain free at present due to the activity restriction. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #7]

Q5: M0420, A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Is pain interfering with the patient's activity?

A5: M0420 identifies the frequency with which pain interferes with a patient's activities, taking into account any treatment prescribed. If a patient is pain-free as a result of the treatment, M0420 should be answered to reflect the frequency that the patient's activities are affected or limited by pain. In this scenario, the patient is described as being pain-free, but also is described as having medication side effects that interfere with activity. Medication side effects are not addressed in responding to M0420 and, given the information in the scenario; pain apparently is not interfering with the patient's activity. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #3]

OASIS ITEM:

(M0430) Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

☐ 0 - No
☐ 1 - Yes

DEFINITION:

Identifies the presence of intractable pain, as defined in the item. To be considered 'intractable,' the pain must meet all three criteria listed in the item:

- not be easily relieved,
- be present at least daily, and
- affect the patient's quality of life as outlined in the item wording.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Intractable pain is pain that occurs at least daily, may make the patient more irritable or less tolerant of frustrations, awakens her/him at night, and makes it difficult to get back to sleep. It may cause the patient to refrain from participating in activities that have been an important part of life, because she/he knows the activity will increase the pain or that the pain will be so significant that he/she can no longer enjoy the activity. A patient who has intractable pain may express much frustration (e.g., crying or anger) at how the pain is interfering with life. As you assess the patient's medications and activities, elicit whether or not the patient's pain fits these descriptions. Ask the patient if the pain is present despite taking analgesic medication regularly as prescribed.

Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual analog pain scales.

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Category 4B – OASIS Data Items

Q1: M0430, Our agency would like clarification of the question concerning how M0430, Intractable pain, is assessed. In our agency, intractable pain is often interpreted as cancer pain. However, the term used in the question, 'not easily relieved' opens the door to very wide interpretation.

A1: In this data item, we are assessing the presence of intractable pain as defined in Chapter 8 of the *OASIS User's Manual*. Intractable pain refers not only to cancer pain but also to pain of other etiologies that occurs at least daily, is not easily relieved, which may affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. This type of pain likely interferes with the patient's activities and needs to be considered when developing the plan of care. [Q&A EDITED 08/07]

Q2: M0430, A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Based on the information provided, would this patient be considered to have intractable pain?

A2: Intractable pain refers to pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. The clinician making the assessment will determine if the patient's pain meets the components of the definition of intractable pain. If the pain is well controlled by round-the-clock pharmacologic interventions, then the pain may not occur daily, and therefore would not be considered intractable. The assessing clinician, with input from the patient, will determine if the pain is easily relieved and will identify the effects of the pain on the patient's activities and life. Note that M0420 and M0430 are separate items and should be assessed and considered separately. There is not an "if response … on M0420, then response … on M0430" algorithm that is appropriate to follow in responding to these items. [Q&A added 06/05] [Q&A EDITED 08/07]

Q3: [Q&A DELETED 08/07; Duplicative of Chapter 8, OASIS User's manual]

Q4: [Q&A DELETED 08/07; Outdated. Terminology deleted from current version of Chapter 8]

Q5: M0430, My patient has post-op pain which initially was well managed with pain medications. For the past few weeks the patient has been refusing to take her pain medications as prescribed due to fear of addiction. This has caused her to have pain that occurs at least daily and impacts her ability to sleep, get around her home, and carry out her home exercise program. The patient is being discharged to outpatient services. On my discharge assessment, I marked that the patient did NOT have intractable pain, because she could have "easily" relieved her pain if she took her pain medications as prescribed. Is this an appropriate application of the current guidance?

A5: The assessing clinician, with input from the patient, will determine if the pain is easily relieved. In your example, it appears that you believe the patient's pain *could* easily be relieved, but in reality it is not relieved due to a fear of addiction. M0430 should be a reflection of the patient's current pain and its current impact on the patient's life, given the current parameters (e.g., pain level and

characteristics, pharmacological and non-pharmacological treatments used). If the patient is not currently using adequate pain medication or non-drug pain management measures, even if they have been prescribed, and are present in the home, M0430 should still be a reflection of the patient's current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #20]

Q6: M0430, My patient reports he can not afford to buy his pain medications, and does have pain that occurs at least daily and interferes with quality of life issues. Can I say that the pain is not easily relieved because the patient does not have a means to relieve it?

A6: Knowledge that the patient is not currently taking medications as prescribed due to financial concerns is certainly an important finding that should be documented in the drug regimen review portion of the comprehensive assessment and addressed in the plan of care. If the patient is not currently using adequate pain medication, for any reason, including inability to afford medications prescribed, M0430 should still be a reflection of the patient's current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #21]

OASIS ITEM:

(M0440) Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

- o 0 -No **[If No, go to *M0490*]**
- o 1 -Yes

DEFINITION:

Identifies the presence of a skin lesion or open wound. A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, surgical incisions, crusts, etc. are all considered lesions. All alterations in skin integrity are considered to be lesions, except alterations that end in "ostomy" (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites. Persistent redness without a break in the skin is also considered a lesion.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient has any skin condition which should be observed and described, mark "yes" to this item.

• Only certain types of wounds are described by specific OASIS items, but other wounds (e.g., burns, diabetic ulcers, wounds caused by trauma of various kinds, etc.), should be documented in a manner determined by each agency. You may mark "1 – Yes" to this item and correctly mark "No" to questions M0445 (Pressure Ulcer), M0468 (Stasis Ulcer), and M0482 (Surgical Wound), if the patient has a different type of wound.

• Pin sites, central lines, PICC lines, implanted infusion devices or venous access devices, surgical wounds with staples or sutures, etc. are all considered lesions/wounds.

• There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. A suprapubic tube site is a cystostomy; an ileal conduit opens in an ileostomy; etc. All "ostomies" are excluded from consideration under this item.

• This item does not address cataract surgery of the eye or gynecological surgical procedures by a vaginal approach.

ASSESSMENT STRATEGIES:

Interview the patient to determine the existence of any known lesions. Follow by visual inspection of the skin. Inspection may reveal additional areas on which to focus interview questions. The comprehensive assessment should include additional documentation of lesion/wound location, size, appearance, status, drainage, etc. if applicable.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
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Category 4B – OASIS Data Items

Q1: M0440, For M0440, Integumentary Status, please clarify CMS's interpretation of a skin lesion.

A1: 'Lesion' is a broad term used to describe an area of pathologically altered tissue. Wounds, sores, ulcers, rashes, crusts, etc. are all considered lesions. So are bruises or scars. In responding to the item, the only 'lesions' that should be disregarded are those that end in 'ostomy' (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites (central line sites are considered to be surgical wounds). For additional types of skin lesions, please consult a physical assessment text.

Q2: M0440, How many different types of skin lesions are there anyway?

A2: Many different types of skin lesions exist. These may be classified as primary lesions (arising from previously normal skin), such as vesicles, pustules, wheals, or as secondary lesions (resulting from changes in primary lesions), such as crusts, ulcers, or scars. Other classifications describe lesions as changes in color or texture (e.g., maceration, scale, lichenification), changes in shape of the skin surface (e.g., cyst, nodule, edema), breaks in skin surfaces (e.g., abrasion, excoriation, fissure, incision), or vascular lesions (e.g., petechiae, ecchymosis).

Q3: M0440, Is a pacemaker considered a skin lesion?

A3: A pacemaker itself is an implanted device but is not an implanted infusion or venous access device. The (current) surgical wound or (healed) scar created when the pacemaker was implanted is considered a skin lesion.

Q4: M0440, How should M0440 be answered if the wound is not observable?

A4: The definition of the term "nonobservable" varies depending on the specific OASIS item being assessed. If you know from referral information, communication with the physician, etc. that a wound exists under a nonremoveable dressing, then the wound is considered to be present for M0440, and the item would be answered "Yes." [Q&A EDITED 08/07]

Q5: M0440, Is a new suprapubic catheter, new PEG site, or a new colostomy considered a wound or lesion?

A5: A new suprapubic catheter site (cystostomy), new PEG site (gastrostomy) and a new colostomy have one thing in common -- they all end in "-ostomy." All ostomies, whether new or long-standing are excluded from consideration in responding to M0440. Therefore, none of these would be considered as a wound or lesion.

Q6: M0440, How should M0440 be answered if the wound/lesion is a burn?

A6: M0440 should be answered, "yes," since a lesion is present. Additional documentation that

describes the burn should be included in the clinical record, but burns are not addressed in the OASIS items. The appropriate ICD-9-CM code for the burn should be entered in M0230 Primary Diagnosis or M0240 as appropriate for accurate documentation. [Q&A EDITED 08/07]

Q7: M0440, Do all scars qualify as skin lesions?

A7: Yes, a scar meets the definition of an "area of pathologically altered tissue." [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #8]

Q8: M0440, If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a skin lesion at M0440?

A8: For M0440 you would answer YES for a lesion and continue answering the questions until you come to M0482 - Does this patient have a surgical wound? Respond Yes - #1. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion.

Q9: M0440, Are implanted infusion devices or venous access devices considered skin lesions at M0440?

A9: Yes, the surgical sites where such devices were implanted would be considered lesions at M0440 and would be included in the total number of surgical wounds (M0484). It does not matter whether the device is accessed at a particular frequency or not. [Q&A EDITED 08/07]

Q10: M0440, How do we document other wounds that are not surgical, pressure ulcers, or stasis ulcers at M0440?

A10: Remember that OASIS items are only PART of a comprehensive assessment and include only those items that have proven useful for outcome measurement and risk factor adjustment. During the early stages of the research on which OASIS items are based, the status of many such lesions were tested for their utility as outcome measures. Only the types of wounds that 'worked' for outcome measurement or risk factor adjustment have been carried forward in OASIS, though other types of wounds are extremely important to document in the clinical record. The presence of ANY wound or lesion (other than ostomies and peripheral IV sites) should be noted by a 'yes' response to M0440. [Q&A EDITED 08/07]

Q11: M0440 – M0488, Do CMS OASIS instructions supersede a clinical wound nurse training program?

A11**:** CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Ulcer Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards. While CMS provides specific instructions on how OASIS data should be classified and reported, OASIS scoring guidelines are not intended to direct or limit appropriate clinical care planning by the nurse or therapist. For instance, even though for OASIS data collection purposes a gastrostomy is excluded as a skin lesion or open wound, such data collection exclusion does not suggest that the clinician should not assess, document and include in

the care plan findings and interventions related to the gastrostomy. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #22]

Q12: M0440/M0482, Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440 and a surgical wound for M0482?

A12: No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #4]

Q13: M0440/M0482, Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?

A13: The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #22]

Q14: M0440/M0445/M0468, Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at M0440 and M0445?

A14: The clinician will have to speak with the physician who must make the determination as to whether a specific lesion is a diabetic ulcer, a pressure ulcer, stasis ulcer, or other lesion. There are some very unique coding issues to consider for ulcers in diabetic patients (vs. ulcers in non-diabetic patients), and the physician should be aware of these in his/her contact with the patient. In responding to the OASIS items, an ulcer diagnosed by the physician as a diabetic ulcer would be considered a lesion (respond "yes" to M0440), but it would not be considered a pressure ulcer or a stasis ulcer.

Q15: Are tracheostomies and thoracostomies excluded from M0440?

A15: There has been conflicting guidance posted on various industry list serves in the recent past. Although some recent guidance from a CMS source referenced otherwise, after further discussion, consensus has been achieved that tracheostomies and thoracostomies are ostomies and excluded from M0440. [Q&A added 1/08; CMS OCCB 1/08 Q&A #19] [Q&A EDITED 05/08]

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

OVERVIEW AND BACKGROUND

As mandated by the Balanced Budget Act of 1997, Home Health Reimbursement shifted to a prospective payment system effective October 2000. Under this system, payment is based on the patient's clinical severity, functional status, and therapy requirements. The system for wound classification uses terms such as "nonhealing", "partially granulating", and "fully granulating"; these terms lack universal definition and clinicians have verbalized concerns that they may be interpreting these terms incorrectly. The WOCN Society has therefore developed the following guidelines for classification of wounds. These items were developed by consensus among the WOCN's panel of content experts.

M0445: Does the patient have a Pressure Ulcer? M0450: Current number of Pressure Ulcers at Each Stage M0460: Stage of Most Problematic (Observable) Pressure Ulcer

1 2 3 4 Stage I Stage II Stage III Stage IV No observable pressure ulcer NA

Definitions:

Pressure Ulcer: Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Shear and friction may be contributing factors. Pressure ulcers are usually located over bony prominences and are staged to classify the degree of tissue damage observed.

□ □ Stage I: Non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.

□ □ State II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents as an abrasion, blister, or shallow crater.

□ □ Stage III: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

□ □ Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts (tunnels) may also be associated with Stage IV pressure ulcers.

□ □ Non-observable: Wound is unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and/or slough cannot be staged, and should be documented as non-observable.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0464: Status of Most Problematic (Observable) Pressure Ulcer

1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable pressure ulcer

Definitions:

- Fully granulating:
  - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
  - no dead space
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges are open
- Early/partial granulation:
  - 25% of the wound bed is covered with granulation tissue
  - there is minimal avascular tissue (eschar and/or slough) (i.e., < 25% of the wound bed is covered with avascular tissue)
  - may have dead space
  - no signs or symptoms of infection
  - wound edges open
- Not healing:
  - wound with 25% avascular tissue (eschar and/or slough) OR
  - signs/symptoms of infection OR
  - clean but non-granulating wound bed OR
  - closed/hyperkeratotic wound edges OR
  - persistent failure to improve despite appropriate comprehensive wound management

Note: A new Stage 1 pressure ulcer is reported on OASIS as Not healing.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0468: **Does the patient have a stasis ulcer?**
M0470: **Current number of Observable Stasis (Ulcer(s)**
M0474: **Does this patient have at least one Stasis Ulcer that cannot be observed?**
M0476: **Status of the Most Problematic (Observable) Stasis Ulcer**
1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable statis ulcer

Definitions:

- Fully granulating:
  - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
  - no dead space
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges are open.
- Early/partial granulation:
  - 25% of the wound bed is covered with granulation tissue
  - there is minimal avascular tissue (eschar and/or slough) (i.e. < 25% of the wound bed is covered with avascular tissue)
  - may have dead space
  - no signs or symptoms of infection
  - wound edges open.
- Not healing:
  - wound with 25% avascular tissue (eschar and/or slough) OR
  - signs/symptoms of infection OR
  - clean but non-granulating wound bed OR
  - closed/hyperkeratotic wound edges OR
  - persistent failure to improve despite appropriate comprehensive wound management

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

M0482: Does the patient have a Surgical Wound? M0484: Current number of (Observable) Surgical Wounds M0486: Does the patient have at least one Surgical Wound that cannot be observed due to the presence of a non-removable dressing?

M0488: Status of the most problematic (Observable) Surgical Wound

1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable surgical wound

Definitions:

- Description/classification of wounds healing by primary intention (i.e. approximated incisions)
  - Fully granulating/healing:
    - incision well-approximated with complete epithelialization of incision
    - no signs or symptoms of infection
  - Early/partial granulation:
    - incision well-approximated but not completely epithelialized
    - no signs or symptoms of infection
  - Not healing:
    - incisional separation OR
    - incisional necrosis OR
    - signs or symptoms of infection
- Description/classification of wounds healing by secondary intention (i.e., healing of dehisced wound by granulation, contraction and epithelialization)
  - Fully granulating:
    - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
    - no dead space
    - no avascular tissue (eschar and/or slough)
    - no signs or symptoms of infection
    - wound edges are open.
  - Early/partial granulation:
    - 25% of the wound bed is covered with granulation tissue
    - there is minimal avascular tissue (eschar and/or slough) (i.e., <25% of the wound bed is covered with avascular tissue)
    - may have dead space
    - no signs or symptoms of infection
    - wound edges are open
  - Not healing: wound with 25% avascular tissue (eschar and/or slough) OR
    - signs/symptoms of infection OR
    - clean but non-granulating wound bed OR
    - closed/hyperkeratotic wound edges OR
    - persistent failure to improve despite comprehensive appropriate wound management

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

GLOSSARY

Avascular:	Lacking in blood supply; synonyms are dead, devitalized, necrotic, and nonviable. Specific types include slough and eschar.
Clean Wound:	Wound free of devitalized tissue, purulent drainage, foreign material or debris
Closed Wound Edges:	Edges of top layers of epidermis have rolled down to cover lower edge of epidermis, including basement membrane, so that epithelial cells cannot migrate from wound edges; also described as epibole. Presents clinically as sealed edge of mature epithelium; may be hard/thickened; may be discolored (e.g., yellowish, gray, or white).
Dead Space:	A defect or cavity
Dehisced/Dehiscence:	Separation of surgical incision; loss of approximation of wound edges
Epidermis:	Outermost layer of skin
Epithelialization:	Regeneration of epidermis across a wound surface
Eschar:	Black or brown necrotic, devitalized tissue; tissue can be loose or firmly adherent, hard, soft or soggy.
Full Thickness:	Tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly into the muscle or bone.
Granulation Tissue:	The pink/red, moist tissue comprised of new blood vessels, connective tissue, fibroblasts, and inflammatory cells, which fills an open wound when it starts to heal; typically appears deep pink or red with an irregular, "berry-like" surface
Healing:	A dynamic process involving synthesis of new tissue for repair of skin and soft tissue defects.
Hyperkeratosis:	Hard, white/gray tissue surrounding the wound
Infection:	The presence of bacteria or other microorganisms in sufficient quantity to damage tissue or impair healing. Wounds can be classified as infected when the wound tissue contains 10^5 (100,000) or greater microorganisms per gram of tissue. Typical signs and symptoms of infection include purulent exudate, odor, erythema, warmth, tenderness, edema, pain, fever, and elevated white cell count. However, clinical signs of infection may not be present, especially in the immunocompromised patient or the patient with poor perfusion.

WOUND OSTOMY AND CONTINENCE NURSES SOCIETY GUIDANCE ON OASIS SKIN AND WOUND STATUS M0 ITEMS

Necrotic Tissue:	See avascular.
Non-granulating:	Absence of granulation tissue; wound surface appears smooth as opposed to granular. For example, in a wound that is clean but non-granulating, the wound surface appears smooth and red as opposed to berry-like.
Partial Thickness:	Confined to the skin layers; damage does not penetrate below the dermis and may be limited to the epidermal layers only
Sinus Tract:	Course or path of tissue destruction occurring in any direction from the surface or edge of the wound; results in dead space with potential for abscess formation. Also sometimes called "tunneling". (Can be distinguished from undermining by fact that sinus tract involves a small portion of the wound edge whereas undermining involves a significant portion of the wound edge.)
Slough:	Soft moist avascular (devitalized) tissue; may be white, yellow, tan, or green; may be loose or firmly adherent
Tunneling:	See sinus tract
Undermining:	Area of tissue destruction extending under intact skin along the periphery of a wound; commonly seen in shear injuries. Can be distinguished from sinus tract by fact that undermining involves a significant portion of the wound edge, whereas sinus tract involves only a small portion of the wound edge.

OASIS ITEM:

(M0445) Does this patient have a **Pressure Ulcer**?

- o 0 -No **[If No, go to *M0468*]**
- o 1 -Yes

DEFINITION:

Identifies the presence of a pressure ulcer, defined as any lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of the underlying tissue. Pressure ulcers most often occur over bony prominences.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Select Response "Yes" if this patient has a pressure ulcer at any stage. (See OASIS item M0450 for definitions of pressure ulcers by stage.)

• Select Response "No" if a former Stage 1 or 2 pressure ulcer has healed AND the patient has no other pressure ulcers. • Select Response “No” if the patient’s skin lesion is any other kind of ulcer or wound.

• Select Response “Yes” if this patient has a Stage 3 or 4 pressure ulcer at any healing status level. (See OASIS item M0450 for definitions of pressure ulcers by stage.)

ASSESSMENT STRATEGIES:

Interview for the presence of risk factors for pressure ulcers (i.e., immobility, activity limitations, skin moisture or incontinence, poor nutrition, limited sensory-perceptual ability). Inspect the skin over bony prominences carefully. It is important to differentiate pressure ulcers from other types of skin lesions. If the home health clinician conducting the assessment is not sure the wound fits the definition of a pressure ulcer, the clinician should contact the physician for clarification.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
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Category 4B – OASIS Data Items

Q1: M0445, If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?

A1: No, covering a pressure ulcer with a skin graft does not change it to a surgical wound. It remains a pressure ulcer. Applying a skin graft to a burn does not become a surgical wound. The burn remains a skin lesion, with details captured in the comprehensive assessment. In either case, a donor site, until healed, would be considered a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #23]

Q2: M0445-M0464, How should these items be answered if a Stage 3 or Stage 4 pressure ulcer is completely healed?

A2: The healing of a pressure ulcer is never indicated by "reverse staging" of the ulcer. If this were the only ulcer the patient had, the appropriate responses would be M0440 = yes and M0445 = yes. M0450 would be answered by indicating the stage of the healed pressure ulcer at its worst, with M0460 answered accordingly. On OASIS item M0464, the "best possible" answer for a healed pressure ulcer would be "fully granulating." [Q&A EDITED 08/07]

Q3: M0445-M0464, If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure?

A3: If a pressure ulcer is closed with a muscle flap, the new tissue completely replaces the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed completely, but then began to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed completely, it would be considered a non-healing surgical wound.

Q4: M0445-M0464, If a pressure ulcer is debrided, does it become a surgical wound as well as a pressure ulcer?

A4: No, as debridement is a treatment procedure applied to the pressure ulcer. The ulcer remains a pressure ulcer, and its healing status is recorded appropriately based on assessment.

Q5: M0445-M0464, If a single pressure ulcer has partially granulated to the surface, leaving the ulcer open in more than one area, how many pressure ulcers are present?

A5: Only one pressure ulcer is present. The healing status of the pressure ulcer (for M0464) can be described by applying the *OASIS Guidance Document,* developed with CMS by the Wound, Ostomy, and Continence Nurses Society (WOCN), found at http://www.wocn.org/ . Other objective parameters such as size, depth, drainage, etc. should also be documented in the clinical record. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q6: M0445 - M0464, We have been advised that a pressure ulcer is always a pressure ulcer and should be staged as it was at its worst. Does this apply to stage 1 and stage 2 pressure ulcers?

A6: Based on current advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), CMS has modified its policy for coding the healing status of Stage 1 and Stage 2 pressure ulcers. This policy became effective September 1, 2004. Stage 1 pressure ulcers heal to normal appearing skin and are not at increased risk for future ulcer development. Stage 2 ulcers generally heal to nearly normal appearing skin, but may result in scar tissue formation. Healed stage 2 pressure ulcers only minimally increase the future risk of pressure ulcers at that location.

During the SOC or subsequent comprehensive assessments of the patient, if it is found that a patient has a healed Stage 1 or 2 pressure ulcer, the responses for OASIS data items are as follows:

(M0440) Does this patient have a Skin Lesion or Open Wound?
- If the patient has a healed Stage 1 pressure ulcer (and no other pressure ulcers OR skin lesions/wounds), the response would be 'No'.
- If the patient has a healed Stage 2 pressure ulcer (and no other pressure ulcers OR skin lesions/wounds), the response may be either 'No' or 'Yes' depending on the clinician's physical assessment of the healed wound site.
- If the patient has no scar tissue formation from the healed Stage 2 pressure ulcer, the accurate response is 'No'.
- If the patient has some residual scar tissue formation, the response is 'Yes'.

(M0445) Does this patient have a Pressure Ulcer?
• If the patient has a healed Stage 1 or 2 pressure ulcer (and no other pressure ulcers), the accurate response is 'No', following the skip pattern as indicated.
[Q&A added 06/05] [Q&A EDITED 08/07]

Q7: M0445-M0464, Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4?

A7: No, a pressure ulcer that is covered with eschar cannot be staged until the wound bed is visible. The status of the pressure ulcer needs to correspond to the visual assessment by the skilled clinician on the date of the assessment. This is documented on the Wound, Ostomy, and Continence Nurses (WOCN) Association website at www.wocn.org in the WOCN Guidance Document and at the NPUAP site at www.npuap.org.
[Q&A added 06/05] [Q&A EDITED 08/07]

Q8: M0445-M0464, If a wound heals and breaks down again should it be staged at its prior level or should it be staged on the current level of breakdown?

A8: The type of wound is not identified here, but this response pertains to a healed pressure ulcer. This is the only type of wound that clinicians can stage. The appropriate response to this question for pressure ulcers will depend on the stage of the pressure ulcer at its worst prior to healing. If the ulcer was a Stage 1 or 2 prior to healing, then the updated guidance included in the response to Q97 (above) should be followed. The stage of this (newly deteriorated) pressure ulcer must be determined based on the current visual assessment by a clinician skilled in this clinical practice. If the ulcer was a Stage 3 or 4 at its worst prior to healing, then the ulcer's stage will be reported according to what it was at its worst. If the ulcer is worse now, the ulcer's stage at its worst (i.e., its current stage) also is what will be reported.

Q9: M0464, According to the WOCN Guidance on OASIS Skin and Wound Status M0 Items, a "non-healing" status applies to a pressure ulcer with greater than or equal to 25% avascular tissue and Early/Partial Granulation status applies to a pressure ulcer with minimal avascular tissue (i.e., less than 25% of the wound bed is covered with avascular tissue). Does this guidance supersede the Chapter 8 M0464 guidance that states "If part of the ulcer is covered by necrotic tissue then it is not healing (Response 3)?" What if only 5% of the wound bed is covered with eschar?

A9: Follow the WOCN guidance. If only 5% of the wound bed is covered with eschar, according to the WOCN guidance, the status would be Early/Partial Granulation, as long as the other criteria are met. To meet the criteria for "Non-healing", the portion of the wound bed coverage must be equal to or greater than 25% avascular tissue. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #25]

Q10: M0445, M0450, M0460 and M0464, Has CMS adopted the new 2/2007 NPUAP *Pressure Ulcer Definitions and Stages* as it relates to OASIS data collection, and therefore, should agencies utilize the new definitions when staging a pressure ulcer even though the language will be different on the item itself (per Chapter 8 Item-by-Item Tips)? For instance, if a patient presents with an ulcer that meets the "Unstageable" definition, how should it be reported on OASIS? And if a patient presents with an ulcer that meets the new "Suspected Deep Tissue Injury" wound definition, how should it be reported on the OASIS?

A10: Clinicians should always follow the most current CMS guidance. Agencies may begin to utilize the 2/2007 NPUAP *Pressure Ulcer Definitions and Stages* in the assessment and reporting of pressure ulcers to the extent permitted by current OASIS implementation instructions.

Unstageable Since the data set does not offer a response of "Unstageable", clinicians should report "Unstageable" pressure ulcers as non observable for M0450 and M0460;

- - M0450 - (e) at least one pressure ulcer that is nonobservable
- - M0460 - NA

The healing status of an unstageable pressure ulcer should be reported in M0464 as either:

-Response 2 - Early/partial granulation, or

-Response 3 - Not healingdepending on the degree of avascular/necrotic tissue present. See the WOCN OASIS Guidance Document for specific guidelines.

Suspected Deep Tissue Injury The new pressure ulcer stage of "Suspected Deep Tissue Injury" is not represented in the current OASIS pressure ulcer items. If the physical wound characteristics of the suspected DTI meet the descriptions included in the staging definitions for pressure ulcers currently listed in M0450, then the DTI should be reported.

If the suspected DTI does not meet the descriptions included in the staging definitions currently listed in M0450, it should not be reported in any of the OASIS pressure ulcer items (M0445-M0464) but would be reported in the clinical documentation. [CMS OCCB 10/07 Q&A #]

Q11: M0445. When answering M0445, how is a pressure ulcer that has been sutured closed categorized?

A11: Since it is relatively uncommon to encounter direct suture closure of a pressure ulcer, it is important to make sure that the pressure ulcer was not closed by a surgical procedure (such as skin advancement flap, rotation flap, or muscle flap). A pressure ulcer that is sutured closed (without a flap procedure) would still be reported as a pressure ulcer.

While this approach (direct suture closure) may rarely be attempted due to a low success rate, home care providers are reporting occurrence. Appropriate guidance for answering the M0450, M0460 and M0464 items would still be found in the WOCN OASIS Guidance Document. While the wound bed of a pressure ulcer sutured shut may not be obscured by necrotic tissue or a non removable dressing, responses to questions relative to staging (e.g., M0450/460) will need to be reported as no observable pressure ulcer. The response to the question relative to status (e.g., M0464) would suggest early/partial granulation, unless specific signs of non-healing are present. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #6]

OASIS ITEM:

(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)

	Pressure Ulcer Stages	Number of Pressure Ulcers				
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 - Yes					

DEFINITION:

Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle "0" for that stage.
- Mark a response for each part of this item: a), b), c), d), and e).
- A pressure ulcer covered by eschar obscuring the depth of tissue loss or covered by a nonremovable cast or dressing cannot be staged, and "yes" should be selected for response (e).
- A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound.

ASSESSMENT STRATEGIES:

Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a bluish/purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth, tissue consistency (firm or boggy feel), or slight edema in these areas. Interview for sensation changes (pain, itching).

The depth of tissue involvement must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar) to the extent that the deepest level of tissue involvement cannot be visualized, the ulcer cannot be staged until sufficient necrotic tissue is removed to allow visualization of the depth of tissue loss. Even a previously-identified Stage 4 ulcer cannot be categorized as a Stage 4 if necrotic tissue currently obscures visualization of involvement of bone, tendon or muscle.

ASSESSMENT STRATEGIES: (Cont'd for OASIS ITEM M0450)

In 2004, based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it was determined that Stage 1 and Stage 2 pressure ulcers can heal. If, on assessment, the patient is found to have a healed Stage 1 or a healed Stage 2 pressure ulcer, this ulcer would not be included in any count of pressure ulcers.

In 2007, the NPUAP released an update to the staging system adding 2 stages, Suspected Deep Tissue Injury and Unstageable pressure ulcers. Pressure ulcers meeting the NPUAP's new definition of "unstageable" would be reported as not observable – "Yes" to M0450(e). Pressure ulcers meeting the NPUAP's new definition of "Suspected Deep Tissue Injury" would only be reported as pressure ulcers on OASIS if additional physical wound characteristics meet the descriptors included in the staging definitions currently listed in M0450.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered appropriately if this occurs.

A healed Stage 3 or Stage 4 pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. A previously-healed Stage 3 or Stage 4 pressure ulcer that breaks down again should be staged at its worst stage.

Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
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Category 4B – OASIS Data Items

Q1: M0450, When staging pressure ulcers, are we to keep the stage the same throughout all assessment time points even though the ulcer is healing? According to AHCPR guidelines for pressure ulcers we should keep the staging the same (once a stage 4 it stays a stage 4 but we document if healing is occurring). Are we to show that a Stage 4 went to a Stage 3 if this occurred at two different time points?

A1: Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is stage 4 at Start of Care and is granulating at the follow-up visit, the pressure ulcer remains a stage 4 ulcer. Your clinical documentation (and possibly the M0464 Status of Most Problematic (Observable) Pressure Ulcer score on a subsequent assessment) will reflect the healing process. The NPUAP web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc. [Q&A EDITED 08/07]

Q2: M0450, M0460, I have reviewed the new 2/07 NPUAP pressure ulcer staging document and it states that a pressure ulcer with slough or eschar can be staged if the necrotic tissue does not obscure the wound bed preventing visualization of tissue loss. There is a CMS OCCB Q&A dated 7/06 that states you cannot stage a pressure ulcer when any amount of eschar or slough is present, even when the bone is visible. Can I stage a pressure ulcer when eschar or slough is present as long as the wound bed is visible?

A2: Yes, you can stage a pressure ulcer when some eschar or slough is present as long as the wound bed is visible and you can see the extent of tissue involved. In response to the latest National Pressure Ulcer Advisory Panel (NPUAP) guidance, we are retracting the CMS OCCB Q&A #24 dated 7/06 that states "any pressure ulcer with any amount of eschar or slough present, even an ulcer with bone visible, would be considered non-observable and therefore could not be staged." In the latest NPUAP staging document, the Stage III pressure ulcer definition states "Slough may be present but does not obscure the depth of tissue loss." The Stage IV pressure ulcer definition states "Slough or eschar may be present on some parts of the wound bed." An Unstageable pressure ulcer has "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined."

The new NPUAP staging document is also consistent with the latest (7/06) WOCN guidance on OASIS skin and wound status M0 items in which the Stage III pressure ulcer definition includes the statement that: "Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia." and that a Stage IV pressure ulcer includes: "Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule)." These definitions state that Stage III and IV pressure ulcers can have necrotic tissue present and therefore are NOT unstageable. The WOCN does go on to explain that a non-observable pressure ulcer is a "Wound unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and /or slough cannot be staged, and should be documented as non-observable." which again is supported by the NPUAP 2/07 document.

These new definitions are consistent with the Chapter 8 guidance for M0450, Current Number of Pressure Ulcers at Each Stage that states "A pressure ulcer cover by eschar or a nonremoveable

cast or dressing cannot be staged…", "The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed." and "Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training."

The 2/07 NPUAP's Pressure Ulcer Staging document can be accessed at www.npuap.org. The WOCN's Guidance on OASIS Skin and Wound Status M0 Items document can be accessed at www.wocn.org . [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #7]

Q3: M0450-M0464. At M0450-M0464, should we document a pressure ulcer when its stage or status worsens?

A3: Absolutely. If a pressure ulcer worsens in stage (or if its status worsens), this information should be noted in M0450 through M0464.

Q4: M0450-M0464, How can one OASIS tell whether a pressure ulcer has improved?

A4: The OASIS items are used for outcome measurement and risk factor adjustment. There are NO outcome measures computed for pressure ulcer improvement. Descriptive documentation in the patient's clinical record should address changes in pressure ulcer size and status that show improvement. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q5: M0450 and M0460, In the NPUAP's 2/2007 Pressure Ulcer Stages document , for the description of a Stage IV pressure ulcer it states "Exposed bone/tendon is visible or directly palpable." What does "directly palpable" mean? I can palpate bone through healthy, intact tissue.

A5: Within the context of answering OASIS M0450 and M0460, "directly palpable" means visible. [CMS OCCB 10/07 Q&A #]

Press Release Pressure Ulcer Stages Revised by NPUAP National Pressure Ulcer Advisory Panel Washington, DC February 2007

The National Pressure Ulcer Advisory Panel has redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original 4 stages and adding 2 stages on deep tissue injury and unstageable pressure ulcers. This work is the culmination of over 5 years of work beginning with the identification of deep tissue injury in 2001.

Pressure Ulcer Definition

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Pressure Ulcer Stages

Suspected Deep Tissue Injury:

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further description:
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Stage I:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further description:
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate “at risk” persons (a heralding sign of risk)

Stage II:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be

used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
*Bruising indicates suspected deep tissue injury

Stage III:

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further description:
The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV:

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further description:
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable:

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as “the body’s natural (biological) cover” and should not be removed.

The staging system was defined by Shea in 1975 and provides a name to the amount of anatomical tissue loss. The original definitions were confusing to many clinicians and lead to inaccurate staging of ulcers associated or due to perineal dermatitis and those due to deep tissue injury.

The proposed definitions were refined by the NPUAP with input from an on-line evaluation of their face validity, accuracy clarity, succinctness, utility, and discrimination. This process was completed online and provided input to the Panel for continued work. The proposed final definitions were reviewed by a consensus conference and their comments were used to create the final definitions. “NPUAP is pleased to have completed this important task and look forward to the inclusion of these definitions into practice, education and research”, said Joyce Black, NPUAP President and Chairperson of the Staging Task Force.

For more information, contact npuap@npuap.org or 202-521-6789

OASIS ITEM:

(M0460) [At Follow-up, skip to M0470 if patient has no pressure ulcers.] **Stage of Most Problematic (Observable) Pressure Ulcer:**

- o 1 -Stage 1
- o -Stage 2
- o -Stage 3
- o -Stage 4
- o NA -No observable pressure ulcer

DEFINITION:

Identifies the most problematic pressure ulcer of those observable pressure ulcers noted in M0450. "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient has only one observable pressure ulcer, then that ulcer is the most problematic.

• In evaluating the most problematic ulcer, do not include any ulcer to which response "e" in M0450 applied. If that is the only ulcer, mark "NA."

• Insert directions at follow-up to skip this item if the patient has no pressure ulcer(s).

• "Nonobservable" pressure ulcers include only those that cannot be observed due to the presence of necrotic tissue (including eschar or slough) which obscures the depth of tissue loss, or a nonremovable dressing (see M0450). Utilize the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document – revised July 2006)* for specific guidance. The web site for WOCN is found at: http://www.wocn.org.

ASSESSMENT STRATEGIES:

Incorporate the information from M0450 and the status of each pressure ulcer and utilize clinical reasoning to determine the most problematic (observable) ulcer.


Wound
Ostomy and
Continence
Nurses
Society

Position Statement: Pressure Ulcer Staging

Statement of Position

The Wound, Ostomy and Continence Nurses (WOCN) Society supports the use of the National Pressure Ulcer Advisory Panel Staging System (NPUAP).[1]

Purpose of Statement

The WOCN Society supports universally recognized terminology and descriptors in the staging of pressure ulcers. The WOCN Society recognizes the importance of staging in the management of acute and chronic pressure ulcers. Accurate assessment, reassessment and documentation are critical for providing evidence of healing, failure to heal or deterioration. Effective communication regarding pressure ulcer staging requires the use of accurate and universally recognized terminology and descriptors.

History

A number of systems have been developed over the years for the classification or staging of pressure ulcers. The staging system currently recommended by the WOCN Society is the NPUAP February 2007 revised definitions of Pressure Ulcers and Stages of Pressure Ulcers.[1] These revisions are a culmination of five years of work by the NPUAP, which began with the identification of deep tissue injury in 2001.

Supportive Statements:

1 Staging of pressure ulcers is only one dimension of pressure ulcer assessment and documentation.

2 Education should be provided by wound care experts to other medical, nursing and lay personnel (including Medicare surveyors, regulatory agencies and third party payers) about the appropriate implementation of the NPUAP Staging System.

3 Assessment and documentation of pressure ulcer status includes comprehensive clinical data demonstrating evidence of progress in healing or failure to heal.

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1 Assessment and documentation of pressure ulcer status includes: -staging -dimensions and depth -presence, location and depth of sinus tracts or undermined areas -status of the pressure ulcer bed (granulating or epithelializing vs. clean but not granulating or avascular) -volume, color and odor of exudate -evidence of infection in surrounding tissue (erythema, induration, crepitance) -status of pressure ulcer edges (closed and nonproliferative vs. open and

proliferative)
2 Assessment data, sequentially recorded over time, can be used to objectively track the progress of the pressure ulcer.
3 The use of descriptors is needed to accurately convey the true state of the pressure ulcer in addition to documenting the stage.
4 Comprehensiveness of a pressure ulcer assessment may vary depending on the care setting and proficiency of the evaluator.

Additional Comments Regarding Staging

1. **Staging of Healing Pressure Ulcers**

   The staging system, as recommended by the NPUAP and the WOCN Society, does not include a stage for granulating pressure ulcers. "Down-staging" of granulating pressure ulcers is not appropriate, since the full-thickness repair process involves replacement of the lost normal tissue with granulation tissue. For example, a granulating stage IV pressure ulcer should not be "down-staged" to a Stage III, because a Stage III pressure ulcer, by definition, is one with exposed subcutaneous tissue. Therefore, a granulating Stage IV pressure ulcer is most appropriately classified as a "granulating Stage IV" or "healing Stage IV." If the Stage IV pressure ulcer is completely healed, it can be classified as a "healed Stage IV," which conveys the pressure ulcer is now filled with granulation tissue and resurfaced with epithelium. When the original depth of the pressure ulcer is unknown and it is resurfaced, the stage cannot be determined by observation. However, when the pressure ulcer is resurfaced, with contracted scar tissue present, the healed pressure ulcer should be described as "evidence of a resurfaced full-thickness pressure ulcer" or "evidence of a resurfaced pressure ulcer of undetermined full-thickness depth."

2. Staging of Pressure Ulcers Totally or Partially Covered with Slough or Eschar

   Pressure ulcers totally or partially covered with slough or eschar cannot be staged until the deepest viable tissue layer or identifiable structure is exposed, because the deepest viable tissue layer is unknown. It is appropriate to document the size, location and appearance of the ulcer as well as the status of the surrounding tissue, and to document "staging cannot be completed until the pressure ulcer base is visible."
   Pressure ulcers partially covered with necrotic tissue but with identifiable muscle, bone or supporting structures (e.g. tendon, joint capsule) visible in the pressure ulcer base can be staged as a stage IV with necrotic tissue because the exposed tissue clearly indicates the ulcer meets the criteria for the most severe pressure ulcer stage. In contrast, a pressure ulcer partially covered with necrotic tissue with viable subcutaneous tissue visible in the

pressure ulcer base cannot be staged, because pressure ulcers penetrating only to the subcutaneous tissue are appropriately classified as a Stage III, and debridement of the remaining necrotic tissue may reveal an area of greater depth such as exposed muscle or bone, indicating the pressure ulcer's true depth is Stage IV.

National Pressure Ulcer Advisory Panel Staging System[1]

Pressure Ulcer Definition

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Suspected Deep Tissue Injury

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue found to be painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further Description:

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Stage I

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further Description:

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

Stage II

Partial thickness loss of dermis presented as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Further Description:

Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
*Bruising indicates suspected deep tissue injury

Stage III
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further Description:
The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further Description:
The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further Description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heel serves as "the body's natural (biological) cover" and should not be removed.

Previous Statements:
Reviewed/Revised: July, 2006
Revised: August, 2007
Adopted: October, 2007

Citations:

1. National Pressure Ulcer Advisory Panel. Updated Pressure Ulcer Stages http://www.npuap.org/pr2.htm. Accessed July, 2007.

References:

Wound, Ostomy and Continence Nurses Society (2003). Clinical Practice Guideline for Prevention and Management of Pressure Ulcers.

Bryant, RA, Nix DP (2007). Acute and Chronic Wounds: Current Management Concepts. St. Louis: Mosby Year Book, 3rd edition

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OASIS ITEM:

(M0464) Status of Most Problematic (Observable) Pressure Ulcer:

- o 1 -Fully granulating
- o -Early/partial granulation
- o -Not healing
- o NA -No observable pressure ulcer

DEFINITION:

Identifies the degree of healing visible in the ulcer identified in M0460 as the most problematic observable pressure ulcer.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Mark the response which most accurately describes the healing process you see occurring in the most problematic pressure ulcer (identified in M0460).

• A Stage 1 pressure ulcer or an infected pressure ulcer is not healing (Response 3).

• ”Nonobservable" pressure ulcers include only those that cannot be observed due to the presence of a nonremovable dressing, including casts. (When determining the healing status of a pressure ulcer for answering M0464, the presence of necrotic tissue does NOT make the pressure ulcer NA – No observable pressure ulcer.)

• A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is Response 2 – Early/partial granulation if necrotic or avascular tissue covers < 25% of the wound bed, or its status is Response 3 - Not healing, if the wound has ≥ 25% necrotic or avascular tissue. See the WOCN *OASIS Guidance Document* for specific guidelines.

ASSESSMENT STRATEGIES:

Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M0460. Utilize the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document - revised July 2006)* to identify the degree of healing evident. The web site for the WOCN is found at: http://www.wocn.org.

OASIS ITEM:

(M0468) Does this patient have a **Stasis Ulcer**?

- o 0 -No **[If No, go to *M0482*]**
- o 1 -Yes

DEFINITION:

A response of "Yes" identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis. Stasis ulcers do not include arterial circulatory lesions or arterial ulcers.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Interview for presence of circulatory disorders and lower extremity skin change in the past health history. Inspect the skin carefully, especially the lower extremities. It is important to differentiate stasis ulcers from other types of skin lesions. If the home health clinician conducting the assessment is not sure the wound fits the definition of a stasis ulcer, the clinician should contact the physician for clarification.

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Category 4B – OASIS Data Items

Q1: M0468-M0476, Would an arterial ulcer be considered a stasis ulcer?

A1: No, because venous stasis ulcers and arterial ulcers are unique disease entities. Refer to the WOCN web site (http://www.wocn.org/) for Clinical Fact Sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).

Q2: M0468-M0476, How can I determine whether the patient's ulcer is a stasis ulcer or not?

A2: The patient's physician is the best information source regarding the root cause of the ulcer. Refer to the WOCN web site (http://www.wocn.org/) for Clinical Fact Sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).

OASIS ITEM:

(M0470) Current Number of Observable Stasis Ulcer(s):

- o 0 -Zero
- o 1 -One
- o 2-Two
- o 3-Three
- o 4 -Four or more

DEFINITION:

Identifies the number of visible (observable) stasis ulcers.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

"Non-observable" stasis ulcers include only those that are covered by a nonremovable dressing.

ASSESSMENT STRATEGIES:

Inspect the skin carefully, especially the lower extremities. Count the ulcerations that can be seen.

OASIS ITEM:

(M0474) Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

- o 0 -No
- o 1 -Yes

DEFINITION:

Identifies the presence of a stasis ulcer which is covered by a dressing that home care staff are not to remove (e.g., an Unna's paste-boot).

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

"Non-observable" stasis ulcers include only those that are covered by a nonremovable dressing.

ASSESSMENT STRATEGIES:

The past health history and current referral information provide knowledge of the reason for any nonremovable dressing. Uncertainty regarding the reason for the nonremovable dressing can be resolved through communication with the physician.

OASIS ITEM:

(M0476) [At Follow-up, skip to M0488 if patient has no stasis ulcers.] **Status of Most Problematic (Observable) Stasis Ulcer:**

- o 1 -Fully granulating
- o -Early/partial granulation
- o -Not healing
- o NA -No observable stasis ulcer

DEFINITION:

Identifies the degree of healing present in the most problematic, observable stasis ulcer. The “most problematic” ulcer may be the largest, the most resistant to treatment, one which is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient has only one stasis ulcer, that ulcer is the most problematic.

• Insert directions at follow-up to skip this item if the patient has no stasis ulcers.

• "Nonobservable" stasis ulcers include only those that are covered by a nonremovable dressing.

ASSESSMENT STRATEGIES:

Inspect each ulcer to determine its status. Based on this information and that from the health history, use clinical reasoning to determine the most problematic (observable) stasis ulcer. Utilize the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document - revised July 2006)* to determine healing status of the stasis ulcer.

OASIS Implementation Manual 1/2008 OASIS Implementation Manual 1/2008

OASIS ITEM:

(M0482) Does this patient have a **Surgical Wound?**

- o 0 -No **[If No, go to *M0490*]**
- o 1 -Yes

DEFINITION:

Identifies the presence of any wound resulting from a surgical procedure. A wound that has completely healed (thus becoming a scar) no longer is identified as a surgical wound.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Orthopedic pin sites, central line sites, stapled or sutured incisions, and wounds with drains are all considered surgical wounds. A surgical incision with approximated edges and a scab (i.e., crust) from dried blood or tissue fluid is considered a current surgical wound.

• A PICC line is not a surgical wound, as it is peripherally inserted, although it could be considered a skin lesion (see M0440).

• Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.

• “Old” surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds.

• A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.

• A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound.

• Cataract surgery of the eye or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for this item.

• Debridement or the placement of a skin graft do not create a surgical wound, as these are treatments performed to an existing wound. The wound would continue to be defined as the type of wound previously identified.

• A "take-down" procedure of a previous ostomy produces a surgical wound. An ostomy being allowed to close on its own is excluded.

ASSESSMENT STRATEGIES:

During the comprehensive head-to-toe assessment, if health history or diagnoses indicate recent surgical procedures performed on the integumentary system, inspect surgical sites. If the home health clinician conducting the assessment is not sure the wound fits the definition of a surgical incision, the clinician should contact the physician for clarification.

Category 4B – OASIS Data Items

Q1: M0482-M0488, Is a gastrostomy that is being allowed to close on its own considered a surgical wound?

A1: A gastrostomy that is being allowed to close would be excluded from consideration as a wound or lesion (M0440), meaning that it could not be considered as a surgical wound. However, the "take-down" of an ostomy done as a surgical procedure would result in both a wound/lesion ("yes" to M0440) and a surgical wound ("yes" to M0482).

Q2: M0482, If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a surgical wound?

A2: For M0440 you would answer YES for a lesion. At M0482, response 1-Yes is appropriate. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion. [Q&A EDITED 08/07]

Q3: M0482, Are implanted infusion devices or venous access devices considered surgical wounds? Are these included in the "count" of surgical wounds? Does it matter whether or not the device is accessed routinely?

A3: Yes, the surgical sites where such devices were implanted would be considered surgical wounds and included in the total number of surgical wounds at M0484. It does not matter whether the device is accessed at a particular frequency or not.

Q4: M0482, If debridement is required to remove debris or foreign matter from a traumatic wound, is the wound considered a surgical wound?

A4: No. Debridement is a treatment to a wound, and the traumatic wound does not become a surgical wound. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #9]

Q5: M0482, If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be "counted" as a surgical wound for M0482, Surgical Wound and the subsequent surgical wound questions?

A5: Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #26]

Q6: M0482, Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or the sutured incision around a fresh ostomy.

A6: No, the presence of sutures does not automatically equate to a surgical wound. In the

examples given, if the IV was peripheral, it would be excluded from M0440 and M0482, and a pressure ulcer does not become a surgical wound by being sutured closed, and the ostomy would be excluded from M0440 and M0482. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #27]

Q7: M0482, Since an implanted venous access device is considered a surgical wound for M0482, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device?).

A7: No. The surgical incision is considered a surgical wound until it is healed, becoming a scar. The site of the venous access device is initially considered a surgical wound, as long as it is in place. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #28]

Q8: M0482, If an abscess is incised and drained, does it become a surgical wound?

A8: No, an abscess that has been incised and drained is an abscess, not a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #29]

Q9: M0482, I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed?

A9: For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. The procedure would be reported as a surgical wound if a drain was placed following the procedure.

Also, if the abscess was surgically excised, the abscess no longer exists and the patient would have a surgical wound, until healed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #17]

Q10: M0482, A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?

A10: When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #18]

Q11: M0482, Does a cardiac cath site qualify as a surgical wound for M0482?

A11: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #19]

Q12: M0482, Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration?

A12: Simply suturing a traumatic laceration does not create a surgical wound. A traumatic wound that required surgery to repair the injury would be considered a surgical wound (e.g., repair of a

torn tendon, repair of a ruptured abdominal organ, or repair of other internal damage), and the correct response to M0482 for this type of wound would be "1-Yes." [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #20]

Q13: M0482, Is a PICC placed by a physician under fluoroscopy and sutured in place considered a surgical wound? It would seem that placement by this procedure is similar to other central lines and would be considered a surgical wound.

A13: Even though the physician utilized fluoroscopy to insert the peripherally inserted central catheter (PICC) and sutured it in place, it is not a surgical wound, as PICC lines are excluded as surgical wounds for OASIS data collection purposes. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #21]

Q14: M0482, If a surgical wound is completely covered with steri-strips is it considered non observable?

A14: Chapter 8 of the OASIS Implementation Manual states, "A [surgical] wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders." Although unusual, if the steri-strip placement did not allow sufficient visualization of the incision, and if the physician provided specific orders for the steri-strips to not be removed, then the wound would be considered not observable. However, a surgical wound with steri-strips should be considered observable in the absence of physician orders to not remove strips for assessment, or if usual placement allows sufficient visualization of the surgical incision to allow observation of clinical features necessary to determine the surgical wound's healing status (e.g., incisional approximation, degree of epithelialization, incisional necrosis (scab), and/or signs or symptoms of infection). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #8]

Q15: M0482, Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed?

A15: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482. The fact that a stent was placed does not have an impact. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #9]

Q16: M0482-M0488, Is a peritoneal dialysis catheter considered a surgical wound? If it is, how can the healing status of this site be determined?

A16: Both M0440 and M0482 should be answered "Yes" for a patient with a catheter in place that is used for peritoneal dialysis. You should consider the catheter for peritoneal dialysis (or an AV shunt) a surgical wound (as are central lines and implanted vascular access devices). To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "nonhealing" unless the signs of not healing are apparent. Such a site, because it is being held open by the line itself, may not reach a "fully granulating" state. Assessing the healing status of such a wound is slightly more difficult than a 'typical' surgical site. As long as a device is present, the wound will be classified as a surgical wound. Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document)* found at http://www.wocn.org/ to determine when healing has occurred.

Q17: M0482-M0488, When does a wound no longer qualify as a surgical wound? When

does CMS officially consider a wound to be healed?

A17: A wound no longer qualifies as a surgical wound when it is completely healed (thus becoming a scar). Utilizing skilled observation and assessment of the wound, follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document*) found at http://www.wocn.org/ to determine when healing has occurred. CMS does not follow time intervals in determining when a wound has healed, since the healing status of the wound can only be determined by a skilled assessment and the time for healing varies widely between patients. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #10]

Q18: M0482-M0488, How should these items be marked when the patient's surgical wound is completely healed?

A18: If the patient's surgical wound has healed completely, it is no longer considered a current surgical wound. The resulting scar would be noted as a "yes" response to M0440, but M0482 would be marked "no."

Q19: M0482-M0488, Is a mediport "nonobservable" because it is under the skin?

A19: Please refer to the definition of “nonobservable” used in the OASIS surgical wound items in the *OASIS User's Manual* – “nonobservable” is an appropriate response ONLY when a nonremoveable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound. If needed, the manual can be downloaded from http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp.[Q&A EDITED 08/07]

Q20: M0482-M0488, I've never seen a nonobservable surgical wound in my agency. Why is this item even included?

A20: There are situations where surgeons do not want others to remove the dressings that they have placed. In such situations, agencies know there is a surgical wound present, but they are unable to describe the wound status because they cannot observe the wound. Without M0486, the responses to the surgical wound item responses might be difficult to evaluate. In the national repository data, nearly 10% (i.e., 9.8%) of patients with surgical wounds at SOC/ROC had nonobservable wounds.

Q21: M0482, Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440, and a surgical wound for M0482?

A21: No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation. [Q&A added 06/05]

Q22: M0482, If a drain was placed post-op and removed prior to admission to home health is the drain site considered a surgical wound upon admission to home care?

A22: A wound with a drain is reported as a surgical wound at M0482. It remains a surgical wound after the drain is pulled until it heals and becomes a scar. [CMS OCCB 10/07 Q&A #]

Q23: If, when reading op reports I find that tissue and/or other structures (mesh, necrotic tissue etc.) were excised when the operation procedure only states I&D, is the resulting wound a surgical wound even though the surgery is labeled I&D?

A23: A simple I&D of an abscess is not a surgical wound for OASIS reporting. A surgical procedure that involves excision of necrotic tissue beyond general debridement (such as excision of a necrotic mass), excision of mesh or other appliances or structures goes beyond a simple I&D and the resulting lesion, until healed, would be reported as a surgical wound for M0482.

Q24: A patient had a skin cancer lesion removed in a doctor's office with a few sutures to close the wound. Is this considered a surgical wound?

A24: A shave, punch or excisional biopsy utilized to remove and/or diagnose skin lesions does result in a surgical wound, until healed.

Q25: M0440/M0482, Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440 and a surgical wound for M0482?

A25: No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #4]

Q26: M0440/M0482, Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?

A26: The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #22]

Q27: Are arthrocentesis sites considered surgical wounds? Thorocentesis sites?

A27: When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate fluid and then removed, (no drain left in place), it should not be reported as a surgical wound. If a physician performs a surgical procedure via arthroscopy, the arthrocentesis site would be considered a surgical wound until it heals and becomes a scar/lesion. [Q&A added 4/08; CMS OCCB 4/08 Q&A #10] [Q&A EDITED 05/08]

Q28: M0482. Is an implanted mechanical left ventricle device (LVAD) that has an air vent exiting through lower right abdomen a surgical wound?

A28: The Left Ventricular Assist Device's (LVAD/HeartMate) cannula exit site would be considered a surgical wound until the LVAD is discontinued and the wound heals and becomes a lesion. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #7]

Q29: M0482. An I&D is not considered a surgery - but a drain inserted during this procedure makes the wound a surgical wound. Dilemma: This makes the OASIS answer for surgical wound a yes but we cannot code aftercare because we don't code the I&D as a surgery - but we do have surgical wound care. This is quite confusing.

A29: The OASIS M0 item response will not always mirror diagnoses and ICD-9 codesfound in M0230 and M0240. Continue to score the OASIS following current CMS guidance, and follow ICD-9 CM coding guidance for code selection for M0230 and M0240. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #8]

Q30: M0482. If staples remain in a surgical wound, would it be considered as not healing?

A30: A surgical wound with staples in place would only be considered not healing if it meets the WOCN Guidance on OASIS Skin and Wound Status M0 Items' definition of not healing. The WOCN guidance can be found at www.wocn.org. Presence of staples, in and of themselves, do not meet the WOCN criteria for non-healing. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #9]

Q31: M0482. Is a chest tube site a surgical wound?

A31: A chest tube site is a thoracostomy. All ostomies are excluded from consideration as a wound or lesion at M0440, Open Wounds or Lesions and therefore should not be considered in any of the subsequent OASIS wound items. A chest tube site is not a surgical wound even if a chest tube or drain is present. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #10]

Q32: M0482 & M0488. When does a surgical wound become "healed" or no longer reportable as a surgical wound on M0482?

A32: For the purposes of determining the healing status for this OASIS item, a surgical wound can be considered fully healed and not reportable as a current surgical wound 4 weeks after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. The resulting scar continues to be reported as a wound/lesion (M0440) and not a surgical wound (M0482-M0488). [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #11]

OASIS ITEM:

(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- o 0 -Zero
- o 1 -One
- o 2-Two
- o 3-Three
- o 4-Four or more

DEFINITION:

Identifies the number of observable surgical wounds.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• A wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders.

• When a single surgical wound heals in a manner that results in one (or more) areas of complete epithelialization with other area(s) of partial healing, each non-epithelialized opening is counted as a separate wound. For example, a vertical laparotomy incision which is epithelialized in some areas, but has an opening at the mid-point and another at the distal point would count as two wounds.

• Each orthopedic pin site is considered a separate wound.

• Each suture or staple insertion site is not considered a separate wound.

ASSESSMENT STRATEGIES:

Count the number of visible wounds.

OASIS ITEM:

(M0486) Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

- o 0 -No
- o 1 -Yes

DEFINITION:

Identifies the presence of a surgical wound which is covered by a dressing (or cast) which is not to be removed, per physician's orders.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Answer yes if there is a wound for which the dressing cannot be removed by home care clinicians (e.g., a plastic surgeon may order that he/she is the only one to remove the dressing over a new skin graft).

ASSESSMENT STRATEGIES:

Review referral information; interview patient; inspect surgical site(s). Contact physician if uncertain about removing dressing.

OASIS ITEM:

(M0488) [At Follow-up, skip to M0490 if patient has no surgical wound(s).] **Status of Most Problematic (Observable) Surgical Wound:**

- o 1 -Fully granulating
- o 2-Early/partial granulation
- o 3-Not healing
- o NA -No observable surgical wound

DEFINITION:

Identifies the degree of healing visible in the most problematic surgical wound. The "most problematic" wound is the one that may be complicated by the presence of infection; location of wound, large size, difficult management of drainage, or slow healing.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Requires identification of the most problematic surgical wound.

• If there is only one surgical wound, the status of that one should be noted.

• Insert directions at follow-up to skip this item if the patient has no surgical wounds(s).

• "Nonobservable" surgical wounds include only those that are covered by a nonremovable dressing (or cast).

• Clinical palpation of a healing ridge is not conclusive and should not be utilized to determine the status of a surgical wound.

ASSESSMENT STRATEGIES:

If there is more than one wound, determine which is the most problematic. Visualize this wound to identify the degree of healing. Utilize the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document - revised July 2006)* to determine the degree of healing. For surgical wounds, note the variation in guidance between those wounds healing by primary intention and those healing by secondary intention.

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Category 4B – OASIS Data Items

Q1: M0488, A venous access device is routinely accessed and upon assessment has a scab at the puncture site. Assuming there are no signs or symptoms of infection, is the wound status early/partial granulation or fully granulating?

A1: To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document)* found at http://www.wocn.org/ to determine the status. Based on the WOCN guidelines, a wound with ≥ 25% avascular tissue is considered "non-healing"; therefore a venous access puncture site which is covered by a scab (avascular tissue) would be classified as Response 3 - non-healing. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #30]

Q2: M0488, Is it true that the status of a new surgical incision that is closed, with no signs or symptoms of infection present, well approximated, but with a small scab, should be evaluated at 3
- Not healing, even though the scab is normal part of incision healing? Since this potentially impacts reimbursement, we want to ensure we are doing it right.

A2: In order to determine the healing status of a surgical wound, clinicians are directed to rely on the "WOCN Guidance on OASIS Skin and Wound Status M0 Items" document available at www.wocn.org. This document provides guidance specific for determining the healing status for surgical wounds healing by primary intention, and separate guidance for wounds healing by secondary intention. A typical routine surgical incision as you describe would be considered healing by primary intention. Referencing the WOCN guidelines, it is noted that a wound that demonstrates incisional necrosis (of any amount for primary intention), is considered "Not Healing". Note that if we were discussing a dehisced wound, we would be assessing a wound healing by secondary intention, and would follow different guidelines which take into consideration the amount of avascular tissue in determining the healing status (e.g. ≥ 25% = not healing). For further clarification, review the CMS OCCB Q&A's (07/2006), Question #30 at www.oasiscertificate.org which confirms that a scab equates to avascular tissue, which the WOCN Document Glossary equates to necrotic tissue. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #10]

Q3: M0488, We are having a discussion as to whether a mediport is a "Not healing" or "Early/partial granulation" wound in M0488 when the needle is present in the wound. And if the needle has just been removed within the last 24 hrs how would it be scored; or if the site has not been accessed for several months and there is no open area visible how is it to be scored? We are assuming that this is a wound that is healing by secondary intention.

A3: The assessing clinician must determine the healing status of a wound following guidance in Chapter 8 of the OASIS User's Manual and the latest version of WOCN's OASIS Guidance Document.

Some sites, because they are being held open by a line or needle, may not reach a "fully granulating" state while the line or needle is in place.

Once the needle is removed before a scab has formed, the wound bed may be clean but non-granulating. Based on the WOCN Guidance, the wound would be reported as Response 3 – Not healing for M0488. Or if the venous access device is routinely accessed and upon assessment has

a scab at the puncture site, assuming there are no signs or symptoms of infection, a wound with greater than or equal to 25% avascular tissue is considered "non-healing". Therefore a venous access puncture site which is covered by a scab (avascular tissue) would also be classified on M0488 as Response 3 – not healing.

If the site has not been accessed for months, then guidance from CMS OASIS Q&As Category 4b Q106 assists in determining the healing status of an implanted vascular access device by suggesting that to answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "non-healing" unless the signs of not healing are apparent. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #11]

Q4: M0482 & M0488. When does a surgical wound become "healed" or no longer reportable as a surgical wound on M0482?

A4: For the purposes of determining the healing status for this OASIS item, a surgical wound can be considered fully healed and not reportable as a current surgical wound 4 weeks after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. The resulting scar continues to be reported as a wound/lesion (M0440) and not a surgical wound (M0482-M0488). [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #11]

Q5: M0488. Does the presence of a "scab" indicate a non-healing wound?

A5: A scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "not healing". This represents a retraction of previous guidance that indicated a scab was considered avascular or necrotic tissue, and therefore an indicator of a non-healing surgical wound. (*Note: This new CMS guidance will supersede prior guidance found in CMS OASIS Q&As; Category 4, Questions 112.1, 112.2, and 112.3).* [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #12]

OASIS ITEM:

(M0490) When is the patient dyspneic or noticeably **Short of Breath**?

- o 0 -Never, patient is not short of breath
- o 1 -When walking more than 20 feet, climbing stairs
- o 2-With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- o 3-With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- o 4 -At rest (during day or night)

DEFINITION:

Identifies the patient's level of shortness of breath.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient usually uses oxygen continuously, mark the response that best describes the patient's shortness of breath while using oxygen.

• If the patient uses oxygen intermittently, mark the response that best describes the patient's shortness of breath WITHOUT the use of oxygen.

• The responses represent increasing severity of shortness of breath.

ASSESSMENT STRATEGIES:

Request to see the bathroom setup, allowing you the opportunity to observe and evaluate the occurrence of shortness of breath with a walk of a distance you can estimate (if less than 20 feet, ask the patient to extend the distance back to a chair). During conversation with the patient, does he/she stop frequently to catch his/her breath? Review symptoms and their severity in past health history. For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. Response 0 would apply if the patient is never short of breath. Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient). See Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.

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Category 4B – OASIS Data Items

Q1: M0490, How should I best evaluate dyspnea for a chairfast (wheelchair-bound) patient? For a bedbound patient?

A1: M0490 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath with varying levels of exertion are presented. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. If the patient does not have shortness of breath with moderate exertion, then either response 0 or response 1 is appropriate. If the patient is never short of breath on the day of assessment, then response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities, then response 1 seems most appropriate. In the case of the bedbound patient, the level of exertion that produces shortness of breath should also be assessed. The examples of exertion given for responses 2, 3, and 4 also provide assessment examples. Response 0 would apply if the patient were never short of breath on the day of assessment. Response 1 would be most appropriate if demanding bed-mobility activities produce dyspnea. [Q&A EDITED 08/07]

Q2: M0490. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.

A2: Since the patient's supplemental oxygen use is not continuous, M0490 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – At rest (during day or night)". It would be important to include further clinical documentation to explain the patient's specific condition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #31]

Q3: M0490, What is the correct response to M0490, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea?

A3: Sleep apnea being treated by CPAP is not the same as dyspnea at rest (response 4 for M0490). M0490 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M0490. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then response 4 - At rest (during day or night) should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #12]

Q4: M0490, Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. Would you mark M0490, #4 At Rest or 0 Never SOB?

A4: M0490 reports what is true at the time of the assessment (the 24 hours immediately preceding the visit and what is observed during the assessment). If the patient has not demonstrated or

reported shortness of breath during that timeframe, the correct response would be “0-Never” even though the environment or patient activities were modified in order to avoid shortness of breath. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #13]

Q5: M0490, Which response for M0490 should be reported for a patient requiring a CPAP (or BiPap) machine at night due to sleep apnea. Since they are apenic at night, would they be considered Response 4 - Short of breath at rest?”

A5: Sleep apnea being treated by CPAP is not the same as dyspnea at rest (response 4 for M0490). M0490 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M0490. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then response 4 - At rest (during day or night) should be reported. [CMS OCCB 10/07 Q&A #]

OASIS ITEM:

(M0500) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- o 1 -Oxygen (intermittent or continuous)
- o 2-Ventilator (continually or at night)
- o 3-Continuous positive airway pressure
- o 4 -None of the above

DEFINITION:

Identifies any of the listed respiratory treatments being used by this patient in the home.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers, Bi-PAP, etc.). These treatments should be documented in the clinical record.

ASSESSMENT STRATEGIES:

Interview patient/caregiver. Review referral information and medication orders. Observe for presence of such equipment in the home.

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Category 4B – OASIS Data Items

Q1: M0500, How should I respond to M0500 for the patient receiving Bi-PAP (not CPAP, as included in response 3)?

A1: Note that the Response-specific Instructions for M0500 direct you to exclude any respiratory treatments that are not specifically listed in the item. If the patient's only respiratory treatment is Bi-PAP without oxygen, the appropriate response is 4, "None of the above." If the patient uses any of the listed treatments, the appropriate response(s) should be noted. If the patient was receiving oxygen, including delivery in conjunction with the Bi-PAP treatment, then the oxygen use would be reported in Response 1. In either case, the use of Bi-PAP would be documented in the patient's clinical record. [Q&A EDITED 08/07]

Q2: M0500, If patient is on a ventilator, do you mark O2 & ventilator or is the O2 inclusive with the ventilator in this question?

A2: M0500 instructs the assessor to mark all that apply. As it is possible for a patient to be ventilated with entrained room air and thus be on a ventilator without oxygen therapy, it would be accurate to mark both Responses 1-Oxygen and 2-Ventilator when the patient is receiving oxygen through the ventilator. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #14]

OASIS ITEM:

(M0510) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

- o 0 -No
- O 1 -Yes
- o NA -Patient on prophylactic treatment
- o UK -Unknown

DEFINITION:

Identifies treatment of urinary tract infection during the past 14 days.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago, mark Response 0 – No.

• Answer “Yes” when the patient had a UTI for which the patient received treatment during the past 14 days.

• Note that if the patient is on prophylactic treatment to prevent UTIs, the appropriate response is “NA.”

• If the patient is on prophylactic treatment and develops a UTI, mark Response 1 – Yes.

• At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

Interview for symptoms and treatment in past health history. Review referral orders. Question the patient about new medications. Confirm with physician if necessary.

Category 4B – OASIS Data Items

Q1: M0510, If a patient had signs and symptoms of a UTI but no prescribed treatment or the treatment ended more than 14 days prior to the assessment, what would be the best response for M0510?

A1: In either of these situations, the appropriate response would be “no.”

OASIS ITEM:

(M0520) Urinary Incontinence or Urinary Catheter Presence:

- o 0 -No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[If No, go to *M0540*]**
- o 1 -Patient is incontinent
- o 2 -Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[Go to *M0540*]**

DEFINITION:

Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0.

• If the patient is incontinent AT ALL (i.e., “occasionally”, “only once-in-a-while”, “sometimes I leak a little bit”, etc.), mark Response 1.

• If the patient requires the use of a urinary catheter for any reason (retention, post-surgery, incontinence, etc.), mark Response 2.

• If the patient is both incontinent and requires a urinary catheter, mark Response 2 and follow the skip pattern.

• A leaking urinary drainage appliance is not incontinence.

ASSESSMENT STRATEGIES:

Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

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Category 4B – OASIS Data Items

Q1: M0520, Is the patient incontinent if she only has stress incontinence when coughing?

A1: Yes, the patient is incontinent if incontinence occurs under any situation(s).

Q2: M0520, A new urologist has just started referring patients who have a urostomy or ureterostomy. What should I mark for M0520?

A2: A urostomy or ureterostomy is considered an ostomy for urinary drainage. The appropriate response therefore is "0 - no incontinence or catheter." The appropriate skip pattern should then be followed.

Q3: M0520, A patient is determined to be incontinent of urine at SOC. After implementing clinical interventions (e.g., Kegel exercises, biofeedback, and medication therapy) the episodes of incontinence stop. At the time of discharge, the patient has not experienced incontinence since the establishment of the incontinence program. At discharge, can the patient be considered continent of urine for scoring of M0520, to reflect improvement in status?

A3: Assuming that there has been ongoing assessment of the patient's response to the incontinence program (implied in the question), this patient would be assessed as continent of urine. Therefore Response 0, no incontinence or catheter, is an appropriate response to M0520.

Timed-voiding was not specifically mentioned as an intervention utilized to defer incontinence. If, at discharge, the patient was dependent on a timed-voiding program to defer incontinence, the appropriate response to M0520 would be 1 (patient is incontinent), followed by response 0 to M0530 (timed-voiding defers incontinence). [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #5]

Q4: M0520, How long would a patient need to be continent of urine in order to qualify as being continent?

A4: Utilize clinical judgment and current clinical guidelines and assessment findings to determine if the cause of the incontinence has been resolved, resulting in a patient no longer being incontinent of urine. There are no specific time frames that apply to all patients in all situations. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #23]

Q5: M0520, How do we answer M0520 for patients who have a percutaneous catheter (nephrostomy)? We are coding the primary diagnosis as V53.6 (fitting urinary catheter).

A5: Follow the Response-Specific instructions for M0520 from Chapter 8 of the OASIS Implementation manual, "If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0". Since your patient has an ostomy for urinary drainage, the nephrostomy, the correct response would be "0". If the patient had the nephrostomy (an ostomy for urinary elimination) and was also incontinent, then Response 1 would be correct. [CMS OCCB 10/07 Q&A #]

Q6: How should we answer M0520 for a patient with a nephrostomy tube? The nephrostomy tube is not discussed directly in the RESPONSE-SPECIFIC INSTRUCTIONS area or Q&As. It does state that if the patient has an ostomy for urinary drainage (e.g. ileal conduit/urostomy, ureterostomy) mark response "0", no incontinence or catheter. Many are interpreting this to mean anything ending in "ostomy" is not a catheter. The problem with this logic is that it would exclude a suprapubic catheter because it is actually a cystostomy.

Can we interpret M0520 to mean if the urinary diversion is pouched with an ostomy appliance it is not a catheter but if it is accessed with a tube or catheter (external or otherwise) then the patient has a catheter? What about the patients with continent urinary diversions? They have a stoma but are accessing with intermittent catheterizations. Would they be reported as having a catheter on M0520?

A6: When a patient has urinary diversion, with or without a stoma that is pouched for drainage the appropriate M0520 response would be "0-No incontinence or catheter". The appropriate response for a patient with urinary diversion, with or without a stoma, that has a catheter or "tube" for urinary drainage would be "2 -Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)." A patient that requires intermittent catheterization would be represented by Response 2, even if they have continent urinary diversions. [Q&A added 4/08; CMS OCCB 4/08 Q&A #11] [Q&A EDITED 05/08]

Q7: M0520. If a patient that has a history of UTI and incontinence, had a urinary catheter in place at the Start of Care (SOC), but the orders are to remove the catheter during the SOC visit, how should we respond to M0520?

A7: When a patient's status varies on the day of the assessment, the clinician reports what is true greater than 50% of the time. If the catheter was pulled during the visit, *"Response 2 – Patient requires a urinary catheter"* would be selected since the catheter was present greater than 50% of the day under consideration.

Don't let this guidance related to the majority of the time confuse you when considering whether or not the patient is incontinent. M0520 is asking what's true on the day of the assessment. Does the patient have a condition on the day of assessment that requires a catheter or causes episodes of incontinence as evidenced by involuntary leakage of urine? The incontinence does not have to occur on the day of assessment, it may only occur occasionally, only once-in-awhile or when coughing, but the condition resulting in the incontinence must be present on the day of the assessment, e.g. weakened pelvic floor or bladder muscles, overactive bladder, neurological conditions, inflammation, prolapsed organs, limited mobility, etc. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #13]

OASIS ITEM:

(M0530) When does **Urinary Incontinence** occur?

- o 0 -Timed-voiding defers incontinence
- o 1 -During the night only
- o 2 -During the day and night

DEFINITION:

Identifies the time of day when the urinary incontinence occurs.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If patient is only "occasionally" incontinent, determine when the incontinence usually occurs.

• Any incontinence that occurs during the day should be marked with Response 2.

ASSESSMENT STRATEGIES:

Once the existence of incontinence is known, ask when the incontinence occurs.

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Category 4B – OASIS Data Items

Q1: M0530, How should I respond to M0530 for the patient with an ureterostomy?

A1: If the patient had an ureterostomy, M0520 should have been answered with response 0 (no incontinence or catheter). From response 0, directions are to skip M0530. You should not be responding to M0530 if the patient has an ureterostomy.

Q2: M0530, If patient had stress incontinence during the day that was not deferred by timed-voiding, how would M0530 be completed?

A2: Response 2 at M0530 is the only response that includes the time period of 'day'. Therefore, that response would be the appropriate one to mark. If there were a caregiver, he/she might consider timed-voiding measures to assist in deferring the patient's incontinence during the day.

Q3: M0530, If a patient is utilizing timed-voiding to defer incontinence and they have an "accident" once-in-a-while, can you still mark M0530 "0 – Timed-voiding defers incontinence"?

A3: If the patient utilizes timed-voiding but still has an "occasional" accident, determine when the accidents occur and mark either Response 1 "during the day and night" or 2 "during the night only". CMS does not offer specific timeframes to define the term "occasionally". Clinical judgment will be required to determine if the last urinary accident is in the relevant past or if the patient's current use of timed-voiding is 100% effective and therefore should be marked as "timed-voiding defers incontinence". [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #32]

OASIS ITEM:

(M0540) Bowel Incontinence Frequency:

- o 0 -Very rarely or never has bowel incontinence
- o 1 -Less than once weekly
- o 2 -One to three times weekly
- o 3 -Four to six times weekly
- o 4 -On a daily basis
- o 5 -More often than once daily
- o NA -Patient has ostomy for bowel elimination
- o UK -Unknown

DEFINITION:

Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does not address treatment of incontinence or constipation (e.g., a bowel program).

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Responses are arranged in order of least to most frequency of bowel incontinence.

• Response “NA” is used if patient has an ostomy for bowel elimination.

• At follow-up and discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient’s responses to these items may make you aware of (an as yet unidentified) problem which needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.

Category 4B – OASIS Data Items

Q1: M0540, How should you respond to this item if the patient is on a bowel-training program? How would that be documented in the clinical record?

A: A patient on a regular bowel evacuation program most typically is on that program as an intervention for fecal impaction. Such a patient may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The patient's elimination status must be completely evaluated as part of the comprehensive assessment, and the OASIS items answered with the specific findings for the patient. The bowel program, including the overall approach, specific procedures, time intervals, etc., should be documented in the patient's clinical record.

OASIS ITEM:

(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days):
a) was related to an inpatient facility stay, or
b) necessitated a change in medical or treatment regimen?

- o 0 -Patient does not have an ostomy for bowel elimination.
- o 1 -Patient's ostomy was not related to an inpatient stay* and did not necessitate change in medical or treatment regimen.
- o 2 -The ostomy was related to an inpatient stay* or did necessitate change in medical or treatment regimen.

DEFINITION:

Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or a change in medical treatment plan.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Applies to any type of ostomy for bowel elimination (i.e., colostomy, ileostomy, etc.).

• If patient does not have an ostomy for bowel elimination, the correct response is 0 - Patient does not have an ostomy for bowel elimination.

• If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.

• If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or change in the medical or treatment regimen.

• At discharge, omit references to inpatient facility stay.

ASSESSMENT STRATEGIES:

Unless an ostomy is mentioned in the referral orders, interview the patient about the presence of an ostomy (or you may have done so when responding to M0540). If the patient has such an ostomy, determine by asking the patient or the physician, whether there have been recent problems with the ostomy, which have necessitated an inpatient facility stay or a change in the medical or treatment regimen.

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Category 4B – OASIS Data Items

Q1: M0550, If a patient with an ostomy was hospitalized with diarrhea in the past 14 days, does one mark Response 2 to M0550?

A1: Response #2 is the appropriate response to mark for M0550 in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

OASIS ITEMS M0560 through M0590, M0610, and M0620: Neuro/Emotional/Behavioral Status Assessment

The next group of OASIS items (M0560 through M0590, M0610, and M0620) addresses aspects of the home care patient's neurologic and mental status. The objective of this portion of the patient assessment is to determine those mental processes or thoughts that interfere with the individual's ability to reach optimal level of function. This assessment includes observation of the patient during the entire assessment process, as well as interview strategies to obtain more specific data about the patient's behavior and interactions with the environment. In addition to the patient, the family, caregiver, physician, or past health history all are important data sources for this assessment.

Observation.

The clinician carefully observes the patient's: (1) posture and motor behavior, (2) manner of dress, (3) facial expressions, (4) grooming and personal hygiene, (5) affect, and (6) manner of speech. All are indicators of the patient's mental status.

Interview.

The interview (of the patient or others) involves a combination of asking questions and waiting as the patient provides the answers in his/her own words. The interview allows the clinician to assess the patient's orientation, attention span, and memory. The clinician begins the interview with open-ended (less directive) questions and proceeds to more specific information gathering as the patient responds. In the interview process, the patient's own percep tion of his/her mood and how this has varied with current health status is explored. The clinician may begin by reporting observations of behavior or mood to the patient: "I notice that you ----." This is followed by assessment of symptoms related to thought processes and behavior, similar to the investigation of physical symptoms such as pain or bleeding. If no symptoms are present, no detailed investigation is warranted; if symptoms are present, a more detailed assessment is necessary. In addition to interview questions about mood or feelings, data concerning current sleep habits, appetite changes, and weight changes are also relevant to the mental status assessment.
An interview protocol to assist the clinician in assessing the patient's current emotional status might include the following suggested questions. If no indications of mood or affective distur bance are present in response to the first few questions, the clinician need not follow the entire protocol. If these indications are present, then follow-up questions are needed.

Can you describe your mood for me?
How are your spirits?
Do you feel this way most of the time?
Are you happy (or unhappy) most of the time?
Have you noticed any change in your feelings or your mood?
Has there been any change in your interest in daily activities?
Have you noticed any change in your outlook on life?
Do you let people know how you feel?
How do you feel life has treated you?
What does the future look like? (If a negative reply, Do things look hopeless?)

Additional assessment strategies are found with each OASIS item in this section.

OASIS ITEM:

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- o 0 -Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- o 1 -Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- o 2 -Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- o 3 -Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- o 4 -Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

DEFINITION:

Identifies the patient's current level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Refers to patient's usual level of functioning.

• Level of cognitive impairment increases as you move down the list of responses.

ASSESSMENT STRATEGIES:

The patient's description of current illness, past health history, and ability to perform ADLs and IADLs allows the clinician to assess cognitive functioning through observation. If the patient is having trouble remembering questions, ask if this is common or because a stranger is asking a lot of questions. Does the patient have trouble remembering friends and/or relatives' names? Does the patient forget to eat or bathe, or get disoriented when walking or traveling (in a car) around the neighborhood or city? If there is a caregiver in the home, gather information from that person also.

OASIS ITEM:

(M0570) When Confused (Reported or Observed):

- o 0 -Never
- o 1 -In new or complex situations only
- o 2 -On awakening or at night only
- o 3 -During the day and evening, but not constantly
- o 4 -Constantly
- o NA -Patient nonresponsive

DEFINITION:

Identifies the time of day the patient is likely to be confused, if at all.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• If it is reported that the patient is “occasionally” confused, identify the situation(s) in which confusion occurs.

• “Nonresponsive” means that the patient is unable to respond.

ASSESSMENT STRATEGIES:

Information can be collected by observation or by report. Observe patient's response to questions about current health status, past health history, symptoms, and ability to perform ADLs and IADLs. Ask the patient whether or not he/she ever feels somewhat confused (e.g., ”you don’t know where you are or how you got here”), and under what circumstances that occurs. Is there a change in attention span? Has recent memory declined? Mild confusion can be masked in patients with well-developed social skills, so careful assessment is needed. If a caregiver or family member is present, they may be able to describe their observations.

Category 4B – OASIS Data Items

Q1: M0570, If a patient has experienced episodes of recent confusion, but does not demonstrate or report any episodes of confusion today (the date of the assessment), would the patient be considered "never" confused? Or should the recent history of confusion be considered when responding to M0570?

A1: Information collected from patient or caregiver report can be utilized in responding to M0570. This includes reports that extend beyond the day of the assessment into the recent past. Therefore, if the patient or family reported that the patient has experienced periods of confusion on awakening a few mornings over the last week, it would be appropriate to mark "2" on awakening or at night only for M0570, even if no confusion was experienced *today*. This same strategy (of utilizing reported information from the recent past) also applies to the scoring of anxiety in M0580 and depressive feelings in M0590. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #11]

Q2: M0570 & M0580, What does unresponsive mean?

A2: It means the patient is unconscious, or is unable to voluntarily respond. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered "unresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simple refuses to answer questions should not automatically be considered "unresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

OASIS ITEM:

(M0580) When Anxious (Reported or Observed):

- o 0 -None of the time
- o 1 -Less often than daily
- o 2 -Daily, but not constantly
- o 3 -All of the time
- o NA -Patient nonresponsive

DEFINITION:

Identifies the frequency with which the patient feels anxious.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• "Nonresponsive" means that the patient is unable to respond.

• Responses appear in order of increasing frequency of anxiety.

ASSESSMENT STRATEGIES:

Information can be collected by observation or by report. Observe posture, motor behavior, facial expressions, affect, and manner of speech. Ask the patient if she/he ever has episodes of feeling very anxious about things. Does the patient wake up at night feeling fearful and anxious and possibly unable to go back to sleep? Is there an increase in irritability or restlessness? Anxiety is often prevalent in patients with chronic respiratory disease, so you may be able to relate the anxiety to increased respiratory difficulty. Consult with family member(s) or caregiver with knowledge of patient behavior.

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Category 4B – OASIS Data Items

Q1: M0570 & M0580, What does unresponsive mean?

A1: It means the patient is unconscious, or is unable to voluntarily respond. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered "unresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simple refuses to answer questions should not automatically be considered "unresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

OASIS ITEM:

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- o 1 -Depressed mood (e.g., feeling sad, tearful)
- o 2 -Sense of failure or self reproach
- o 3 -Hopelessness
- o 4 -Recurrent thoughts of death
- o 5 -Thoughts of suicide
- o 6 -None of the above feelings observed or reported

DEFINITION:

Identifies presence of symptoms of depression.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Feelings may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe for indicators of these feelings throughout the assessment. Validate initial impressions with interview questions, (e.g., “I noticed that---. Can you describe your mood for me?”). Follow the suggested protocol on page 8.82 to assess for presence of any depressive symptoms. If depressive feelings are present, inquire about the presence of suicidal thoughts. (If suicidal thoughts are present, inquire whether these have evolved into a plan for self-harm.)

Category 4B – OASIS Data Items

Q1: M0590. If a patient is on an antidepressant and symptoms are fairly well controlled, how would M0590 be answered?

A1: M0590 reports whether or not the patient has symptoms of depression, either observed or reported. The time period under consideration is the day of assessment and the recent pertinent past (as determined by the assessing clinician). If the patient does not have symptoms of depression as a result of an antidepressant drug regimen, then the appropriate response would be "*6 - None of the above feelings observed or reported*". If the patient is taking an antidepressant medication and still demonstrates or reports depressive symptoms, then one or more M0590 responses may be reported, dependent on the specific symptom(s) observed/reported. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #14]

OASIS ITEM:

(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)

- o 1 -Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- o 2 -Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- o 3 -Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- o 4 -Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- o 5 -Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- o 6 -Delusional, hallucinatory, or paranoid behavior
- o 7 -None of the above behaviors demonstrated

DEFINITION:

Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Behaviors may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history, interview for the current presence of these behaviors at the stated frequency, i.e., at least weekly. Consult with family or caregiver familiar with patient behavior.

OASIS ITEM:

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- o 0 -Never
- o 1 -Less than once a month
- o 2 -Once a month
- o 3 -Several times each month
- o 4 -Several times a week
- o 5 -At least daily

DEFINITION:

Identifies frequency of behavior problems which may reflect an alteration in a patient's cognitive or neuro/ emotional status. "Behavior problems" are not limited to only those identified in M0610. For example, "wandering" is included as an additional behavior problem. Any behavior of concern for the patient's safety or social environment can be regarded as a problem behavior.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Behavior problems may be observed by the clinician or reported by the patient, family, or others.

ASSESSMENT STRATEGIES:

Observe patient for the presence of these behaviors throughout the entire assessment. If present, validate the frequency of their occurrence. In the health history, interview for the presence of these behaviors at the stated frequency, over a period of time sufficient to determine the current frequency of occurrence. Consult with family or caregiver familiar with patient behavior.

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Category 4B – OASIS Data Items

Q1: M0620, Are the behaviors to be considered in responding to this item limited to only those listed in M0610?

A1: No, there are behaviors other than those listed in M0610 that can be indications of alterations in a patient's cognitive or neuro/emotional status resulting in behaviors of concern for the patient's safety or social environment. Other behaviors such as wandering can interfere with the patient's safety, and if so, the frequency of these should be considered in responding to the item.[Q&A EDITED 08/07]

OASIS ITEM:

(M0630) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- o 0 -No
- o 1 -Yes

DEFINITION:

Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation or experience.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

If the clinician performing the assessment is not the qualified psychiatric nurse, review the current plan of care to determine whether such services are currently being provided.

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Category 4B – OASIS Data Items

Q1: M0630, At discharge, does M0630 pertain to the services the patient has been receiving up to the point of discharge or services that will continue past discharge? The psych nurse is the only service being provided.

A1: OASIS items refer to what is true at the time of the assessment (unless a specified time point is noted, such as 14 days ago). Therefore, for the situation described, if the psych nurse is the only service provided at the time of the discharge assessment, the correct response is "yes." Note that if the psychiatric nurse discharges on Tuesday, but the Physical Therapist does the discharge comprehensive assessment on Wednesday, then M0630 (at discharge) would not reflect the presence of psychiatric nursing services. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #3]

NOTE: For OASIS items M0640-M0820, the patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies, chose the response describing the patient's ability more than 50% of the time. See the *OASIS User's Manual* page 8.89 for more details.

OASIS ITEMS M0640 through M0820: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

The next group of OASIS items (M0640 through M0820) addresses the patient's functional status. Level of functioning is an important indicator of the patient's ability to remain in the home setting, as the goals of many home care interventions are to assist the patient to restore capability or to maintain maximum capacity as long as possible. Patient functioning is not the domain of only one professional group, but typically requires coordinated efforts among disciplines to achieve functional goals.

Activities of Daily Living (ADLs) include basic self-care activities (e.g., bathing, grooming, dressing, etc.), while Instrumental Activities of Daily Living (IADLs) include activities associated with independent living necessary to support the ADLs (e.g., housekeeping, laundry, shopping, etc.). IADLs usually require some degree of both cognitive and physical ability. Because home care patients have health-related needs, OASIS IADL items include management of medications and health-care related equipment.

The clinician should complete the OASIS items according to the patient's ABILITY, not necessarily actual performance for the defined item. "Willingness" and "compliance" are not the focus of these items. The patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink, should be scored on ability to bathe in tub/shower, not actual performance.

These items address the patient's ability to safely perform the specified activities, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform ADLs and IADLs. Ability can be temporarily or permanently limited by:

-physical impairments (e.g., limited range of motion, impaired balance)
-emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
-sensory impairments, (e.g., impaired vision or hearing, pain)
-environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry).

The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies, choose the response describing the patient's ability more than 50% of the time.

Direct observation, supplemented by interview, is the preferred method for assessing a patient's ADL and IADL abilities. If direct observation of an activity is not possible, item score(s) should be based on all observed and reported information available. Specific assessment strategies for each OASIS ADL/IADL item are included with the item definitions.

All OASIS ADL/IADL scales present the most independent level first, then proceed to the most dependent. The word "unable" is underlined the first time it describes a change from "able" to "unable" in the responses. Read each response carefully to determine which one best describes what the patient is able to do.

The "current" ADL/IADL status must be completed for all assessments. "Prior" status is included for start (or resumption) of care. Prior refers to the patient's status 14 days before the start/resumption of care. Adhere rigidly to the 14-day criterion: If the patient was in a hospital at that time, describe the ADL/IADL status as of that day. Obtaining prior status information nearly always requires an interview approach.

OASIS ITEM:

(M0640) **Grooming:** Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). \

Prior	Current	
___	___	0 -Able to groom self unaided, with or without the use of assistive devices or adapted methods.
___	___	1 -Grooming utensils must be placed within reach before able to complete grooming activities.
___	___	2 -Someone must assist the patient to groom self.
___	___	3 -Patient depends entirely upon someone else for grooming needs.
___	___	UK -Unknown

DEFINITION:

Identifies the patient's ability to tend to personal hygiene needs, excluding bathing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability Resumption of care - prior and current ability Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities but unable to do less frequently performed activities should be considered to have more grooming ability.

• Response 2 includes standby assistance or verbal cueing.

• "UK - Unknown" is an option only in the "Prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient gathering equipment needed for grooming. The patient can verbally report the procedure used for grooming and demonstrate the motions utilized in grooming (e.g., hand to head for combing, hand to mouth for teeth care, etc.). The clinician should also observe the general appearance of the patient (to assess grooming deficiencies) and verify upper extremity strength, coordination, and manual dexterity to determine if the patient requires assistance with grooming. A poorly groomed patient who possesses the coordination, manual dexterity, upper-extremity range of motion, and cognitive/emotional status to perform grooming activities should be evaluated according to his/her ability to groom.

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Category 4B – OASIS Data Items

Q1: M0640-M0800, At OASIS items M0640-M0800, what does IADL mean and what's the difference between IADLs and ADLs?

A1: ADL stands for 'activities of daily living' while IADL stands for 'instrumental activities of daily living'. ADLs refer to basic self-care activities (e.g., bathing, dressing, toileting, etc.), while IADLs include activities associated with independent living necessary to support the ADLs (e.g., use of telephone, ability to do laundry, shopping, etc.). There is a more complete discussion of this topic in the *OASIS User's Manual*, Chapter 8, Item-by-Item tips, on the page preceding the tips for items M0640-M0800.

Q2: M0640-M0800, With regard to the start of care data set, what time frame do we select for IADL's/ADL's if we are to complete 'prior' 14 days before start of home care and the patient was in the hospital at that time? Is this 14 days prior to the hospitalization or 14 days before start of care, which would be while the patient was in the hospital?

A2: For M0640 - M0800, the time frame for the 'prior' ADL/IADLs should reflect the 14th day directly before start of home care, which would be while the patient was in the hospital.

Q3: M0640-M0800, I know it is imperative that the assessing clinician be accurate on answering what the patient's status was on the "14th day prior to". Can you explain to me the importance of that 14th day? What bearing this has on their outcomes/payment? If we mark "unknown", does it hurt the agency?

A3: Prior status contributes to the Case Mix Report categories of "ADL Status Prior to SOC" and "IADL Status Prior to SOC" and is utilized in risk adjustment for some of the outcome measures. The "prior status" variables have proven to be particularly useful in risk adjustment for the OBQI reports, as they indicate the chronicity of a functional impairment (thus impacting the patient's expected ability to improve in a specific outcome of interest). The 14th day prior to SOC/ROC serves as a proxy for the patient's prior functional status. While it may not represent the "true" prior functional status, it allows the data collection of thousands of assessors to be standardized. General OASIS conventions state that data collectors should minimize the use of "unknown" as a response option, and to limit its use to situations where no other response is possible or appropriate. Under the current reimbursement for Medicare home care services, the "14 days prior" responses do not affect payment. However, since the responses from the prior status items do currently contribute to risk adjustment, it is possible that they may have a reimbursement impact in the future, depending on the parameters used to determine payment under the home health benefit and other programs. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #24]

Q4: M0640, Must I see the patient comb his/her hair or brush his/her teeth?

A4: No, as assessment of the patient's coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient's ability to perform grooming activities.

Q5: M0640, Is toileting hygiene part of this item?

A5: The term “toileting hygiene” typically is used to refer to the activities of managing clothing before and after elimination and of wiping oneself after elimination. If these are the activities implied by this question, the response is “no, toileting hygiene is not part of this item.” If the question refers to the patient’s ability to wash his/her hands, this activity is considered part of grooming.

Q6: M0640 & M0670, Is hair washing/shampooing considered a grooming or bathing task?

A6: The task of shampooing hair is not considered a grooming task for M0640. Hair care for M0640 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M0670, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #34]

OASIS ITEM:

(M0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Prior	Current	
___	___	0 -Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
___	___	1 -Able to dress upper body without assistance if clothing is laid out or handed to the patient.
___	___	2 -Someone must help the patient put on upper body clothing.
___	___	3 -Patient depends entirely upon another person to dress the upper body.
___	___	UK -Unknown

DEFINITION:

Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient requires standby assistance (a "spotter") to dress safely or requires verbal cueing/reminders, then Response 2 applies.

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

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Category 4B – OASIS Data Items

Q1: M0650, If the patient is wearing a housecoat, should I evaluate her ability to dress in the housecoat or in another style of clothing?

A1: The appropriate response should indicate the patient's ability to dress herself (or the level of assistance needed to dress) in whatever clothing she would routinely wear. If the patient routinely wears another style of clothing, the assessment should include the skills necessary to manage zippers, buttons, hooks, etc. associated with this clothing style.

Q2: M0650, What if the patient must dress in stages due to shortness of breath? What response must be marked?

A2: If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then response 2 is appropriate. (Note that the shortness of breath would be addressed in M0490.)

Q3: M0650 & M0660, In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing?

A3: M0650 & M0660, Upper and Lower Body Dressing, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the assessment time point, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #25]

Q4: M0650, M0660 & M0780, For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"? The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"

A4**:** Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more

important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

OASIS ITEM:

(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Prior	Current	
___	___	0 -Able to obtain, put on, and remove clothing and shoes without assistance.
___	___	1 -Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
___	___	2 -Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
___	___	3 -Patient depends entirely upon another person to dress lower body. UK -Unknown

DEFINITION:

Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient must apply a lower-extremity prosthesis, this prosthesis should be considered as part of the lower-body apparel.

• If the patient requires standby assistance (a "spotter") to dress safely or verbal cueing/reminders, Response 2 applies.

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

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Category 4B – OASIS Data Items

Q1: M0660, If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g. patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M0660?

A1: M0660 identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. A prescribed treatment that is integral to the patient's prognosis and recovery from the episode of illness, such as elastic compression stockings, air casts, etc., should be considered when scoring M0660. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items, as the elastic compression stockings are a required, prescribed treatment. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #35]

OASIS ITEM:

(M0670) Bathing: Ability to wash entire body. **Excludes grooming (washing face and hands only).**

Prior	Current			
☐	☐	0	-	Able to bathe self in shower or tub independently.
☐	☐	1	-	With the use of devices, is able to bathe self in shower or tub independently.
☐	☐	2	-	Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.
☐	☐	3	-	Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
☐	☐	4	-	Unable to use the shower or tub and is bathed in bed or bedside chair.
☐	☐	5	-	Unable to effectively participate in bathing and is totally bathed by another person.
☐		UK	-	Unknown

DEFINITION:

Identifies the patient's ability to bathe entire body and the assistance which may be required to safely bathe in shower or tub. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- The patient who bathes independently at the sink must be assessed in relation to his/her ability to bathe in tub or shower. Is assistance needed for the patient to bathe in tub or shower? If so, what type of assistance?
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then Response 2 or Response 3 applies, depending on the quantity of assistance needed.
- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities.
- If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, Response 0 or 1 would apply, depending on the need for devices to safely perform the task independently.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.

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Category 4B – OASIS Data Items

Q1: M0670, For patients whose regular habit is to sponge bathe themselves at the lavatory, what should be marked for M0670?

A1: As noted in the Item-by-Item Tips found in Chapter 8 of the *OASIS User's Manual*, the patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her ability to bathe in the tub or shower. What assistance would be needed for the patient to be able to wash their body in the tub or shower? For example, if it is determined that the patient would be able to safely wash their body in the shower or bathe in the tub with the presence of another person throughout the bath for safety or assistance, response #2 would be marked. [Q&A EDITED 08/07]

Q2: M0670, Given the following situations, what would be the appropriate responses to M0670?

a) The patient's tub or shower is nonfunctioning or is not safe for use.
b) The patient is on physician-ordered bed rest.
c) The patient fell getting out of the shower on two previous occasions and is now afraid
and unwilling to try again.
d) The patient chooses not to navigate the stairs to the tub/shower.

A2: a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower. b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment. c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then response 3 would describe her ability. d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured. [Q&A EDITED 08/07]

Q3: M0670, How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink?

A3: The item addresses the patient's ability to bathe in the shower or tub, regardless of where or how the patient currently bathes. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and response 1, 2, or 3 should be selected.

Q4: M0670, Should the clinician consider the patient's ability to perform bathing-related tasks, like gathering supplies, preparing the bath water, shampooing hair, or drying off after the bath in responding to this item?

A4: When responding to M0670, only the patient's ability to "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #12]

Q5: M0670, If a patient can perform most of the bathing tasks (i.e. can wash most of his/her body) in the shower or tub, using only devices, but needs help to reach a hard to reach place, would the response be "1" because he/she is independent with devices with a "majority" of bathing tasks? Or is he/she a "2" because he/she requires the assist of another "for washing difficult to reach areas?"

A5: The correct response for the patient described here would be Response 2 "able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas," because that response describes that patient's ability at that time. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #13] [Q&A EDITED 08/07]

Q6: M0670, Please clarify how the patient's ability to access the tub/shower applies to M0670.

A6: M0670 defines the bathing item to identify the patient's ability to wash the entire body. Guidance for this item also indicates that when medical restrictions prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. Tasks related to transferring in and out of the tub or shower are evaluated and scored when responding to M0690 – Transferring, and they are not considered part of the bathing tasks for M0670. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #6]

Q7: M0670, A patient is unable to participate in the bathing tasks and is totally bathed by a caregiver, but the caregiver bathes the patient in the shower (i.e., lifts the patient into a shower chair, rolls patient to the shower, and bathes the otherwise passive patient). Response 5 states that the patient is unable to effectively participate in bathing and is totally bathed by another person. Please clarify if this patient would be noted to be at response level 5 because they are unable to effectively participate in bathing and are totally bathed by another person or at level 3 because the patient requires the presence and assistance of another person to bathe in the shower?

A7: If the patient truly is unable to effectively participate in any part of the bathing tasks in the shower, response 5 is appropriate. If the patient is able to participate at all in the bathing tasks in the shower, then response 3 is appropriate. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #6]

Q8: M0670, If the only reason the patient can't bathe in the tub is because they can't perform the transfer safely, even with equipment and assistance, should they be at response level 4 or 5 (Unable to use the shower or tub) even though the only reason is the transfer status, and transferring is not supposed to be considered in responding to M0670?

A8: The tub transfer should not be considered when responding to M0670. However, the response for M0670 should differentiate patients who are able to bathe (or be bathed) in the tub or shower (i.e., responses 0, 1, 2, 3, or 5) from those who are unable to bathe in the tub or shower (e.g., response 4) regardless of the specific cause or barrier preventing the patient from bathing in the shower or tub. Responses 0,1,2,3, reflect patients who are able to get in/out of the tub/shower, assisted or unassisted by any safe means and once in the tub/shower are able to safely participate

in washing their body, either independently or with assistance. Responses 4 reflects patients who are unable to get in/out of the tub/shower, assisted or unassisted by any safe means and therefore participate in washing their body outside of the tub/shower, either independently or with assistance. Response 5 reflects patients who are unable to participate in the tasks required to wash their body, regardless of whether or not the patient is able to get in/out of the tub/shower (e.g. the dependent bather is bathed in the bed, chair, or after being rolled into the shower in a shower chair). [[Q&A added 06/05; Previously CMS OCCB 3/05 Q&A Q #7] [Q&A EDITED 08/07]

Q9: M0670, Since the transfer into/out of the tub/shower should not be considered when responding to M0670, is it acceptable for assessing clinicians to ignore Response 2(b) from the item wording?

A9: The tub or shower transfer should not be considered when responding to M0670, and if the transfer is the only bathing task for which a patient requires help to bathe safely in the tub/shower, then the patient should be scored a 0 or 1, depending on his/her need for devices to safely perform all the included bathing tasks independently. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #8]

Q10: M0670, Based on my SOC comprehensive assessment, I determine that my patient requires assistance to wash his back and feet safely in the tub. At the time of the assessment, I believe the patient *could* wash his back and feet safely *if* he had adaptive devices, like a long-handled sponge. Should the initial score be "1" able to bathe in the tub/shower with equipment or "2" requires the assistance of another person to wash difficult to reach areas?

A10: Since at the time of the assessment the patient requires intermittent assist of another person to wash difficult to reach areas, then response "2" should be selected. If the clinician determined that the patient could become more independent (i.e., require less assistance) with the use of adaptive equipment, then such equipment could be obtained or recommended as part of the home health plan of care. If at discharge the patient is able to wash his entire body using the equipment provided, then response "1" should be reported. If the patient is financially unable or otherwise refuses to obtain the recommended equipment, then the clinician would not have the opportunity to instruct or evaluate the patient's ability to determine if the equipment improves independence. If the patient does not get the equipment, or if even with the equipment the patient continues to require intermittent assistance, then response "2" would apply. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #36]

Q11: M0670, I understand that recent clarification reveals that the transfer in/out of the tub/shower should not be included in the scoring of M0670. Previous guidance stated that in order for the patient to be able to bathe in the tub/shower they had to be able to get there (e.g., if a patient is restricted from stair climbing and their only tub/shower is upstairs, then they are unable to bathe in the tub/shower) Is this still true or is M0670 now limited to just the patient's ability to wash their entire body once in the tub/shower? It seems strange that walking up the stairs *would* impact the bathing item score, but getting into the tub/shower *wouldn't*.

A11: Guidance for this item has evolved over time and additional clarification has been provided, allowing objective measurement of improvement in a specific portion of the bathing process; the patient's ability to wash their entire body. If a patient can get to the tub/shower and in/out of the tub/shower (by any safe means), then their ability to wash their entire body while in the tub/shower should be assessed, and the score reported as "0" if they need no human assistance or equipment, "1" if they need no human assistance but require equipment, "2" if they require intermittent assistance, "3" if they require constant supervision/assistance, "4" if they are unable to use the

shower or tub and is bathed in bed or bedside chair, or “5” if they are unable to participate at all in washing their body. If medical restrictions prohibit the patient from activities which would be required for the patient to get to/from the tub/shower (e.g., restricted stair climbing), in/out of the tub/shower (e.g., some joint precautions), or from bathing or showering in the tub or shower (e.g., some cast or incision precautions), then the patient should be considered “unable to bath in the tub or shower” and would be scored a “4” or “5”, depending on their ability to participate in washing their body at any location outside of the tub/shower. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #37]

Q12: M0670, For M0670 even the normal person requires a long-handled sponge or brush to wash their back. However, the July 27 CMS OCCB Q & A's # 36 indicates that if a patient can do everything except wash their back & requires a long-handled sponge or brush they would be marked a "1". Is this correct?

A12: Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to, or had great difficulty safely performing. The intention of the use of the term “devices” in the response 1 for M0670 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not "require" special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient’s use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient’s ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines “devices” for the scoring of M0670. The clinician should assess the patient’s ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #27]

Q13: M0670, If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a "4" in M0670?”

A13: Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient’s personal preference to bathe at the sink (e.g. “I don’t get that dirty.” “I like using the sink.”), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient’s ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower when it was empty. If the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient as “4 – “Unable to use the shower or tub and is bathed in bed or bedside chair.”, unless they are a “5”, unable to participate in bathing and is totally bathed by another person. Note that the response of “4” (or “5”) is due to the patient’s inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #28]

Q14: M0640 & M0670, Is hair washing/shampooing considered a grooming task, a bathing

task, or neither?

A14: The task of shampooing hair is not considered a grooming task for M0640. Hair care for M0640 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M0670, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #34]

OASIS ITEM:

(M0680) Toileting: Ability to get to and from the toilet or bedside commode.

Prior	Current	
___	___	0 -Able to get to and from the toilet independently with or without a device.
___	___	1 -When reminded, assisted, or supervised by another person, able to get to and from the toilet.
___	___	2 -Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
___	___	3 -Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
___	___	4 -Is totally dependent in toileting.
___	___	UK -Unknown

DEFINITION:

Identifies the patient's ability to safely get to and from the toilet or bedside commode. Excludes personal hygiene and management of clothing when toileting. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability Resumption of care - prior and current ability Follow-up - current ability Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders, then Response 1 applies.

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

• If the patient can get to and from the toilet during the day, but uses the commode at night for "convenience," Response 0 applies.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely use the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

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Category 4B – OASIS Data Items

Q1: M0680, If my patient has a urinary catheter, does this mean he is totally dependent in toileting?

A1: M0680 does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient's ability to get to and from the toilet or bedside commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

Q2: M0680, If the patient can safely get to and from the toilet independently during the day, but uses a bedside commode independently at night, what is the appropriate response to this item?

A2: If the patient chooses to use the commode at night (possibly for convenience reasons), but is able to get to the bathroom, then response 0 would be appropriate.

Q3: M0680, If a patient is unable to get to the toilet or bedside commode and uses a bedpan for elimination, what response applies if the patient is able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?

A3: In M0680, the patient does not need to empty the bedpan or urinal to be considered independent. If the patient required assistance to use the bedpan/urinal (i.e., get on or off the bedpan or position the urinal), Response 4 would be the best response. If the patient could position the urinal or get on/off the bedpan independently, Response 3 would be appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #14]

Q4: M0680, The Item-by-Item pages in Chapter 8 state that personal hygiene and management of clothing are not included in scoring, so could "independent use of bedpan" as indicated by response "3" allow someone to help with clothing management and hygiene and still be considered "independent?"

A4: Tasks related to personal hygiene and management of clothing should not be considered when responding to M0680. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #15]

Q5: M0680, If a patient is able to safely get to and from the toilet with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M0680?

A5: The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet with assistance, then response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #9]

Q6: M0680, Is the transfer on/off the toilet included in responding to M0680? What about the transfer on/off the bedside commode? What about the transfer on/off the bed pan?

A6: M0680 does not include the transfer on and off the toilet (for response levels 0 and 1) or on/off the bedside commode (for response 2), as both these transfers are specifically addressed in responding to M0690 - Transferring. The transfer on and off the bedpan *is* considered for M0680 response level 3. If the patient requires assistance to get on/off the bedpan, then he/she would not be considered independent in using the bedpan and response 4 would be the best response. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #10]

Q7: M0680, If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of responding to M0680?

A7: Yes, a patient who is able to safely get to and from the toilet should be scored at response levels 0 or 1, even if they require the use of a commode over the toilet. Note that the location of such a commode is not at the "bedside," and the commode is functioning much like a raised toilet seat. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #11]

Q8: M0680 & M0700, We have several nurses that have recently joined our staff, all coming from the same agency. They were taught that on all OASIS questions if there is the word OR in bold that if both sides of the word "OR" pertained to the patient, then the patient would automatically be scored at the next level down. For example on question M0700, if the patient requires use of a device to ambulate AND needs human supervision on unlevel surfaces then the patient would be scored as a #2 which says "able to walk only with the supervision or assistance of another person at all times". However on M0680 transfer question they are marking a "0" saying the patient is on a level surface so the patient can independently get to the toilet with a device. Our software does not want to accept this; it considers it an inconsistency in data.

Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement, that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "2" on M0700 for ambulation, can the patient be a "0" independent in toileting?

A8: When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 8 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M0670 Bathing says "Able to bathe self in shower or tub independently. If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M0700, Ambulation/Locomotion, response option 2 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently is reported as a "1" (See CMS OASIS Q&A Category 4b Question 155 for further guidance related to scoring M0700).

For M0690, Transferring, Response 1-Transfers with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "2" for M0700, Ambulation/Locomotion. A patient can only be scored a "0" for M0680, Toileting, if they can get to and from the toilet independently with or without a device. It would be possible for a patient to be a "2" for M0700, Ambulation/Locomotion and also be reported as a "0" for M0680, Toileting, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet safely and without assistance using a wheelchair. [CMS OCCB 01/08 Q&A #21]

OASIS ITEM:

(M0690) **Transferring:** Ability to move from bed to cha r, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current	
___	___	0 - Able to independently transfer.
___	___	1 - Transfers with minimal human assistance or with use of an assistive device.
___	___	2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
___	___	3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
___	___	4 - Bedfast, unable to transfer but is able to turn and position self in bed.
___	___	5 - Bedfast, unable to transfer and is unable to turn and position self.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient is able to transfer self, but requires standby assistance to transfer safe , or requires verbal cueing/reminders, then Response 1 applies.
- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).
- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other, then Response 3 must be selected.
- If the patient is bedfast, the ability to turn and position self in bed is assessed.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine accurate response for this item. Ask the patient about transferring ability. Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do not mean that the patient is not independent. Observe the patient during transfers and determine the amount of assistance required for safe transfer. If ability varies between the transfer activities listed, record the level of ability applicable to the majority of those activities. When the patient demonstrates ambulation/locomotion, shows the clinician to the bathroom/kitchen, and demonstrates ability to get into and out of tub/shower, transferring can be assessed simultaneously.

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Category 4B – OASIS Data Items

Q1: M0690, My patient must be lifted from the bed to a chair. He cannot turn himself in bed and is unable to bear weight or pivot. How would I respond to M0690?

A1: Response 3 is the option that most closely resembles the patient's circumstance you describe. The patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast ("confined to the bed") even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast.

Q2: M0690, If other types of transfers are being assessed (e.g., car transfers, floor transfers), should they be considered when responding to M0690?

A2: Because standardized data are required, only the specific transfer tasks listed in M0690 should be considered when responding to the item. Based on the patient's unique needs, home environment, etc., transfer assessment beyond bed to chair, toilet/commode, or tub/shower transfers may be indicated. Note in the patient's record the specific circumstances and patient's ability to accomplish other types of transfers.

Q3: M0690, If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?

A3: You appear to be asking about a patient who is not bedfast. Remember that M0690 evaluates the patient's ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of tub or shower. "Pushing up with both arms" could apply to two of these transfer types -- bed to chair and on/off toilet or commode. Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is not independent. If standby human assistance were necessary to assure safety, then a different response level would apply to these types of transfers. Remember that transfer ability can vary across these three activities. The level of ability applicable to the majority of the activities should be recorded.

Q4: M0690, When scoring M0690 – Transferring, response "1" indicates that that patient requires minimal human assistance or the use of an assistive device to safely transfer. What constitutes an "assistive device" for the purposes of differentiating "truly independent" transferring (response "0") from "modified independent" transferring (response "1", or transferring with equipment)?

A4: CMS is in the process of defining assistive devices and will provide guidance when the issue is clarified. [Q&A ADDED 08/07. Previously CMS OCCB 08/04 Q&A #16]

Q5: M0690, If a patient requires a little help from the caregiver to transfer (e.g., verbal cueing, stand by assist, contact guard), would the score for M0690 Transferring be "1" (requires "minimal human assistance") or a "2" ("unable to transfer self")? Both seem to apply.

A5: If the patient is able to transfer self but requires standby assistance or verbal cueing to safely

transfer, response “1” would apply. If the patient is unable to transfer self but is able to bear weight and pivot when assisted during the transfer process, then response “2” would apply. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #38]

Q6: M0690, A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M0690, is the patient considered bedfast?

A6**:** A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed. [Q&A ADDED 8/07; Previously CMS OCCB 05/07 Q&A #29]

Q7: M0690, How do you select a score for M0690 – Transferring, for the patient who is not really safe at response 1, but moving to response 2 seems a bit aggressive? Response 1 uses the word "or" NOT "and". If a patient requires both human assist AND an assistive device, does this move them to a 2, especially if they are not safe? It seems these patients can do more than bear weight and pivot--but it is the next best option. If they require human assist AND an assistive device, should we automatically move the patient to a "2", whether they are safe or not?

A7: If the patient is able to safely transfer with either minimal human assistance (but no device), or with the use of an assistive device (but no human assistance) then they should be reported as a “1- Transfers with minimal human assistance or with use of an assistive device”. If they are not safe in transferring with either of the above circumstances, (e.g., they transfer with only an assistive device but not safely, minimal assistance only is not adequate for safe transferring, or they require both minimal human assistance and an assistive device to transfer safely), then the patient would be scored a “2– Unable to transfer self but is able to bear weight and pivot during the transfer process“(assuming the patient could bear weight and pivot). Safety is integral to ability. If the patient is not safe when transferring with just minimal human assistance or with just an assistive device, they cannot be considered functioning at the level of response “1”. For the purposes of Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete the task. Examples of environmental set-up as it relates to transferring would be a patient who requires someone else to position the wheelchair by the bed and apply the wheelchair locks in order to safely transfer from the bed to the chair, or a patient who requires someone else to place the elevated commode seat over the toilet before the patient is able to safely transfer onto the commode. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #15]

Q8: M0690, The patient is severely disabled with MS, is obese, cannot support her weight and the spouse is able to use a Hoyer lift to transfer her to a chair. Because of her size, she is not able to use a bedside commode. The bathroom entrance and layout does not allow for the Hoyer to pass through, so the patient is unable to be transferred to the bathroom toilet or into the shower. She can only do one of the three transfers via lift. She is not "confined to the bed" because she is able to be lifted to a chair. When in bed, she needs help turning and positioning. Is she a response 3 or a 5? Which principles apply and how would the transfer question be scored in this instance?

A8: When selecting the correct response to a multi-task item like Transferring, you must first determine if your patient is bedfast or not. If the patient is bedfast, the response will be 4 or 5. If the patient is not bedfast and their ability varies between the three transfers, determine what is true in a majority of the more frequently performed transfers. Bedfast means that a patient is unable to tolerate being out of the bed. They are confined to the bed. You state that your patient is transferred out of bed via the Hoyer lift and sits in a chair, so she is not bedfast. Even though the patient is only able to perform one of the three transfers, due to environmental and physical barriers, Response 3 best describes this patient. In the most frequently performed transfer, she is unable to transfer self and is unable to bear weight or pivot when transferred by another person. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #16]

Q9: When scoring M0690, Transferring, the assessment revealed difficulty with transfers. The patient was toe touch weight bearing on the left lower extremity and had pain in the opposite weight bearing hip. The patient had a history of falls and remained at risk due to medication side effects, balance problems, impaired judgment, weakness, unsteady use of device and required assistance to transfer. The concern is the safety of the transfers considering all of the above. Would "2" or "3" be the appropriate response?

A9: Safety is integral to ability, if your patient requires more than minimal human assistance or they need minimal assistance and an assistive device to safely transfer, and can bear weight and pivot safely, Response 2 should be reported. If you determine the bearing weight and pivoting component of the transfer is not safe even with assistance, then the patient is not able to bear weight or pivot and the appropriate selection would be Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person. [Q&A Added 10/07, CMS OCCB 10/07 Q&A]

Q10: M0690. For M0690, Transferring, does the transfer from bed to chair include evaluation from a seated position in bed to a seated position in a chair or from supine in bed to seated in a chair? How does the location of a chair affect the assessment? For example, is the transfer from bed to chair assessed when the environment does not allow for placement of a chair next to the bed and the patient must walk to the next room to reach one?

A10: M0690 assesses the patient's ability in safe performance of three specified transfers: bed to chair, on and off the toilet or commode and into and out of the tub/shower. The bed to chair transfer includes the patient's ability to get from the bed to a chair. For most patients, this will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair. If the patient is unable to perform one of the specified transfers due to an environmental barrier (e.g. there is no toilet or commode in the home, no tub/shower or chair in which to transfer from the bed), then M0690 would report the patient's ability in the performed transfers. If the patient's ability varies among the performed transfers, the clinician should select a response that reflects the patient's ability in a majority of the most frequently performed transfers. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #15]

OASIS ITEM:

(M0700) Ambulation Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current	
___	___	0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
___	___	1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
___	___	2 - Able to walk only with the supervision or assistance of another person at all times.
___	___	3 - Chairfast, unable to ambulate but is able to wheel self independently.
___	___	4 - Chairfast, unable to ambulate and is unable to wheel self.
___	___	5 - Bedfast, unable to ambulate or be up in a chair.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's ability and the type of assistance required to safe ambulate or propel self in a wheelchair over a variety of surfaces. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Follow-up - current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient requires standby stance to safely ambulate or requires verbal cueing/reminders, Response 1 or Response 2 applies, depending on the quantity of assistance needed.
- Responses 3 and 4 refer to a patient who is unable to ambulate, even with the use of assistive devices and assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 3 or 4, based on ability to wheel self.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- Medical restrictions should be taken into consideration (as with all other ADL items), as the restrictions address what the patient is able to do safely.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe the patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

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Category 4B – OASIS Data Items

Q1: M0700, What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are able to do and what they are allowed to do may be different. How should I respond to this item?

A1: The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

Q2: M0700, Does M0700 include the ability to use a powered wheelchair or only a manual one?

A2: The OASIS item does not differentiate between the ability to use a powered wheelchair or a manual one.

Q3: M0700, If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of "chairfast?"

A3: Item M0700 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose response 0, 1, or 2, whichever is the most appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #17]

Q4: M0700, How would I score a patient who does not use an assistive device, but does sometimes need help on level/even surfaces?

A4: A patient who needs intermittent assistance (including any combination of hands-on assistance, supervision, and /or verbal cueing) to ambulate safely would be scored as a "1" on M0700. A patient who needs continuous assistance (including any combination of hands-on assistance, supervision, and/or verbal cueing) to ambulate safely would be scored as a "2" -- "able to walk only with the supervision or assistance of another person at all times." [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #7]

Q5: M0700, My patient does not have a walking device but is clearly not safe walking alone. I evaluate him with a trial walker that I have brought with me to the assessment visit and while he still requires assistance and cueing, I believe he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he usually is just up stumbling around on his own. What score should I select for M0700?

A5: It sounds as though your assessment findings cause you to believe the patient should have someone with them at all times when walking (Response "2"). When scoring M0700, clinicians should be careful not to assume that a patient, who is unsafe walking without a device, will suddenly (or ever) become able to safely walk *with* a device. Observation is the preferred method of data collection for the functional OASIS items, and the most accurate assessment will include observation of the patient using the device. Often safe use will require not only obtaining the

device, but also appropriate selection of specific features, fitting of the device to the patient/environment and patient instruction in its use. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #39]

Q6: M0700, For M0700, does able to walk "on even and uneven surfaces" mean inside the home or outside the home or both? If the patient is scored a 0, does this mean the patient is a safe community ambulator and therefore is not homebound?

A6: "Even and uneven surfaces" refers to the typical variety of surfaces that the particular home care patient would routinely encounter in his environment. Based on the individual residence, this could include evaluating the patient's ability to navigate carpeting or rugs, bare floors (wood, linoleum, tile, etc.), transitions from one type or level of flooring to another, stairs, sidewalks, and uneven surfaces (such as a graveled area, uneven ground, uneven sidewalk, grass, etc.).
To determine the best response, consider the activities permitted, the patient's current environment and its impact on the patient's normal routine activities. If, on the day of assessment, the patient's ability to safely ambulate varies among the various surfaces he must encounter, determine if the patient needs some level of assistance at all times (Response 2), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), or needs some human assistance and/or equipment at times but not constantly (Response 1).

Response 0, Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e. needs no human assistance or assistive device), is not intended to be used as a definitive indicator of homebound status. Some patients are homebound due to medical restrictions, behavioral/emotional impairments and other barriers, even though they may be independent in ambulation.
Refer to the Medicare Coverage Guidelines for further discussion of homebound criteria at http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf . [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #30]

Q7: How would an agency report M0110 and M0826 when the patient has a HMO/MCO insurance (and is managed by Medicare) when they require a HIPPS code? What if they *don't* require a HIPPS Code?

A7: If the payer requires an HHRG/HIPPS, M0110 should be answered Early, Later or Unknown and M0826 should reflect the number of reasonable and necessary therapy visits planned for the episode. If the payer does not need the HHRG/HIPPS, M0110 and M0826 should be answered NA.

The agency will need to communicate with their non-Medicare Traditional Fee-for-Service (PPS) patient's payer to determine if they require a HHRG/HIPPS. [Q&A added 01/08; CMS OCCB 01/08 Q&A #12] [Q&A EDITED 06/08]

OASIS ITEM:

(M0710) Feeding or Eating: Ability to feed self mea s and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior	Current	
___	___	0 - Able to independently feed self.
___	___	1 - Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent ass stance or supervision from another person; OR (c) a liquid, pureed or ground meat diet.
___	___	2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
___	___	3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
___	___	4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
___	___	5 - Unable to take in nutrients orally or by tube feeding.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item excludes evaluation of the preparation of food items. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Meal "set-up" (n Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. -- all of which are special adaptations of the meal for the patient.
- Responses 3, 4, and 5 include non-oral intake.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Determine the amount and type of assistance that is needed by the patient to feed himself/herself once the food is placed in front of him/her. During the nutritional assessment, determine whether special preparations (i.e., pureeing, grinding, etc.) must occur for food to be swallowed or whether tube feedings are necessary.

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Category 4B – OASIS Data Items

Q1: M0710, How should M0710 be answered if the patient is being weaned from a feeding tube? The tube is still present but is not being used for nutrition.

A1: If the tube is being used to provide all or some nutrition, responses 3-5 apply. Once the tube is no longer used for nutrition, even if it remains in place, the patient's ability to feed himself/herself should be reported using response 0, 1, or 2. The presence of the feeding tube and diet information should be detailed elsewhere in the clinical documentation.

Q2: M0710, What if the patient cannot carry his food to the table? He is able to feed himself, to chew, and to swallow.

A2: You should respond to this item based on the assistance needed by the patient to feed himself, once the food is placed in front of him. If no assistance is needed, then response 0 applies. If some assistance is required, response 1 applies. Because you indicate that the patient is able to feed himself, response 2 would not be appropriate.

Q3: M0710, For Feeding or Eating, what is the definition of meal set-up?

A3: Meal set-up is included in Response 1 of M0710, Feeding or Eating. When reviewing Response 1, you will see that it is identifying patients who are able to feed self independently but need some special assistance to do so. With this in mind, meal set-up would include any special assistance that is required for the patient that others do not require in order to feed themselves once the food is placed in front of them. Examples of meal set-up activities that a patient may require assistance with include cutting the food into manageable pieces, buttering bread, or placing a straw in a cup. (Note: Chopping or cutting of food is not considered meal set-up in homes where the culture dictates that the food be chopped or cut before being served, such as in some Asian cultures.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #40]

OASIS ITEM:

(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

Prior	Current	
___	___	0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered mea
___	___	(b) Is physical y, cognitively, and mental y able to prepare light meals on a regular basis but has not routine y performed light meal preparation in the past (i.e., prior to this home care admission).
___	___	1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
___	___	2 - Unable to prepare any light meals or reheat any delivered meals.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Response 1 indicates patient can intermittently (i.e., sometimes) prepare light meals, while Response 2 indicates patient cannot prepare light meals.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals (whether or not he/she currently does this)? Utilize observations made during the assessment of cognitive status, ambulation, grooming, dressing, and other activities of daily living (ADLs) to assist in determining the best response to this item. The patient's own dietary requirements should be considered when evaluating the ability to plan and prepare light meals.

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Category 4B – OASIS Data Items

Q1: M0720, Should a therapeutic diet prescription be considered when assessing the patient's ability to plan and prepare light meals for M0720? For example, if a patient is able to heat a frozen dinner in the microwave or make a sandwich – but is NOT able to plan and prepare a simple meal within the currently prescribed diet (until teaching has been accomplished for THAT diet, or until physical or cognitive deficits have been resolved), would the patient be considered *able* or *unable* to plan and prepare light meals?

A1: M0720 identifies the patient's cognitive and physical ability to plan and prepare light meals or reheat delivered meals. While the nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when scoring M0720. Therefore a patient who is able to complete the mobility and cognitive tasks that would be required to heat a frozen dinner in the microwave or make a sandwich, but who is currently physically or cognitively *unable* plan and prepare a simple meal that complies with a medically prescribed diet should be scored as a "1- unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations," until adequate teaching/learning has occurred for the special diet, or until related physical or cognitive barriers are addressed. If the patient with any prescribed diet requirements is unable to plan and prepare a meal that complies with their prescribed diet AND also is unable to plan and prepare "generic" light meals (e.g. heating a frozen dinner in the microwave or making a sandwich), Response 2 – Unable to prepare any light meals or reheat any delivered meals" should be selected. This is a critical assessment strategy when considering the important relationship between this IADL and nutritional status. A poorly nourished patient with limited ability to prepare meals is at greater risk for further physical decline. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #8] [Q&A EDITED 08/07]

Q2: M0826, We are having a huge discussion as to what the meaning of the new M0826question implies. At present if the admission is done by nursing any rehabilitation service is put on the 485 (plan of care) as a 1 day 1 for evaluation and treatment. Then later the rehabilitation service enters their own orders and frequency as a verbal order after they have completed therapy evaluation. The way the new M0826 reads, some feel the nurse must put on the 485 a total of rehabilitation visits to match the OASIS number placed in the blank even though the rehabilitation service may or may not have made their evaluation visit to the patient by the time the POT and OASIS are to be completed. We realize CMS will adjust the actual number of visits later as the claim is processed but are we expected to put the guess on the 485 at the start of care? Is this a compliance issue?

A2: Chapter 8 of the OASIS User's manual, on page 8.112, states under the Definition"Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the CMS OCCB Q&As – January 2008 (www.oasiscertificate.org) Page 11 of 11 treatment of the patient's illness or injury." It further states under Assessment Strategies "If the number of visits that will be needed is uncertain, provide your best estimate." [Q&A added 01/08; CMS OCCB 01/08 Q&A #12] [Q&A EDITED 06/08]

OASIS ITEM:

(**M0730)** **Transportation:** Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

Prior	Current	
___	___	0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
___	___	1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
___	___	2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
___		UK - Unknown

DEFINITION:

Identifies the patient's physical and mental ability to safely use a car, taxi or public transportation. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to safely use transportation and the type of assistance required. Utilize observations made during the assessment of ambulation, transferring, and other activities of daily living (ADLs) to assist in determining the best response to this item.

Category 4B – OASIS Data Items

Q1: M0730, My patient's son drives her to doctor's appointments, because she has not driven for years. The patient prefers her son do this, rather than taking public transportation. How would I respond to M0730?

A1: Remember that the item addresses what the patient is able to do, not what she prefers. A person who has not driven for years is not likely to be able to safely and independently drive a car at the time of the assessment. However, if the patient were able to use a regular or handicap-accessible public bus, response level 0 would be appropriate.

OASIS ITEM:

(M0740) Laundry: Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

Prior	Current	
___	___	0 - (a) Able to independently take care of all laundry tasks; OR (b) Physically, cognitively, and mentally able to do laundry and access facilities, but routinely performed laundry tasks in the past (i.e., prior to this home care admission).
___	___	1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
___	___	2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's physical, cognitive, and mental ability to do laundry, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of the care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

The ability to do laundry is impacted by the patient's environment (i.e., is the washing machine on the same floor, in the same building, etc.). The patient's ability to do laundry in his/her own environment should be considered in responding to this item. "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ability to do laundry, even if this task is not routinely performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other activities of daily living to assist in determining the best response to this item. Awareness of the location of laundry facilities (from the environmental assessment) is also needed.

OASIS ITEM:

(**M0750)** **Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Prior	Current	
___	___	0 - (a) Able to independently perform all housekeeping tasks; OR (b) Physically, cognitively, and mental y able to perform al housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission).
___	___	1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) independently.
___	___	2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
___	___	3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
___	___	4 - Unable to effectively participate in any housekeeping tasks.
___	___	UK - Unknown

DEFINITION:

Identifies the physical, cognitive and mental ability of the patient to perform both heavier and lighter housekeeping tasks, even if the patient does not routinely carry out these activities. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of the care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to complete housekeeping, even if these tasks are not routine y performed. Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

OASIS ITEM:

(M0760) Shopping: Ability to plan for, select, and purchase items n a store and to carry them home or arrange delivery.

Prior	Current	
___	___	0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR (b) Physically, cognitively, and mental y able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).
___	___	1 - Able to go shopping, but needs some assistance: (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR (b) Unable to go shopping alone, but can go with someone to assist.
___	___	2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
___	___	3 - Needs someone to do all shopping and errands.
___	___	UK - Unknown

DEFINITION:

Identifies the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about the ability to plan for, select, and purchase items from the store, even if these tasks are not routinely performed. How are medications, groceries, or needed medical supplies obtained? Utilize observations made during the assessment of cognitive status, ambulation, transferring, and other ADLs to assist in determining the best response to this item.

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Category 4B – OASIS Data Items

Q1: M0760, If I select response 0 or response 1, will the patient's homebound status be questioned?

A1: For all the ADL/IADL OASIS items, the patient's ability to perform the tasks is the focus of the assessment. The frequency of leaving the home to shop or the amount of effort needed, two criteria often associated with homebound status, are not the assessment focus here. Refer to the Medicare Benefits Policy Manual available at http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf or contact your Regional Home Health Intermediary (RHHI) for issues related to homebound status and other Medicare payment related issues. [Q&A EDITED 08/07]

OASIS ITEM:

(M0770) Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

Prior	Current	
___	___	0 - Able to dial numbers and answer calls appropriately and as desired.
___	___	1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
___	___	2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
___	___	3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
___	___	4 - Unable to answer the telephone at all but can listen if assisted with equipment.
___	___	5 - Totally unable to use the telephone.
___	___	NA - Patient does not have a telephone.
___	___	UK - Unknown

DEFINITION:

Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

• "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Does the patient have access to a telephone? Information obtained during assessment of cognitive, behavioral, and other ADL assessments may be helpful in determining the most accurate response for this item. The safety assessment also provides data regarding emergency plans - how is the ability to use a telephone related to these plans?

OASIS ITEM:

(M0780) Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Prior	Current	
___	___	0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
___	___	1 - Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) given daily reminders; OR (c) someone develops a drug diary or chart.
___	___	2 - Unable to take medication unless administered by someone else.
___	___	NA - No oral medications prescribed.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's ability to prepare and take oral medications reliably and safe y and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Exclude injectable and IV medications.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.
- Only medications whose route of administration is "po" should be considered for this item. Medications given per gastrostomy (or other) tube are not administered "po," but are administered "per tube."
- The patient who sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of this would be considered independent in administration.
- If another person must create the medication list or set up the "planner device" for the patient, then Response 1 applies.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening medication containers. Ask the patient to state the proper dosage for each medication and the correct times for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item. If patient's ability to manage medications varies from medication to medication, consider total number of medications and total daily doses in determining what is true most of the time.

Category 4B – OASIS Data Items

Q1: M0780, Do you consider medications given through a gastrostomy tube (M0780) oral medications?

A1: Item M0780 is assessing the patient's ability to take all oral medicines. The route of administration for medications given/taken by G-tube is 'per G-tube', not 'po'. Therefore, medications whose route is listed as per G-tube are NOT oral medications.

Q2: M0780, My patient sets up her own pill planner. How would I answer M0780?

A2: If your patient is able to take the correct medication in the correct dosage at the correct time as a result of this set up, then you would consider her independent and response 0 would apply. If your patient relies on a list of medications created by another person to set up her pill planner, response 1 would be more appropriate. If the patient follows a list that she made herself, she is independent and response 0 would apply.

Q3: M0780, I have had several patients who use a list of medications to self-administer their meds. Would this be considered a drug diary or chart?

A3: Yes, this is considered a drug diary or chart. The statement for response 1c ("someone" develops a drug diary or chart) pertains to someone other than the patient developing the aid. What you need to assess is whether the patient must use this list to take the medications at the correct times. If he/she does require the list and also requires someone else to create it, then response 1 is the appropriate choice. [Q&A EDITED 08/07]

Q4: M0780, Some assisted living facilities require that facility staff administer medications to residents. If the patient appears able to take oral medications independently, how would the clinician answer M0780?

A4: M0780 refers to the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility's requirement. You would certainly want to document the requirement in the clinical record.

Q5: M0780, For a patient who is independent (response level 0) with all medications except one, which he/she is unable to take without being administered by someone else, would the last statement in the item-by-item instructions ("If patient's ability to manage medications varies from medication to medication, consider the total number of medications and total daily doses in determining what is true most of the time") require that M0780 be marked as 0?

A5: Following the instructions quoted above, the clinician must determine the total number of daily doses involved to determine what is true most of the time. For example, a patient who had two medications, one of which was taken once daily and one of which was taken 4-6 times a day (e.g., Parkinson's medications), and was independent with taking both medications the first time in the morning, but needed reminders to take the remaining 3-5 doses of the second medication,

Response 1 would be appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #18]

Q6: M0780, When scoring M0780, Management of Oral Medications, should medication management tasks related to filling and reordering/obtaining the medications be considered?

A6: No. Tasks related to filling, reordering and obtaining medications are considered part of the instrumental activity of daily living – shopping task, and they are evaluated during the scoring of M0760. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #19]

Q7: M0780, When scoring M0780 – Management of Oral Medications, should assessment include only prescription medications? Or should over-the-counter oral medications be included as well?

A7: Scoring of M0780 should include all oral medications, prescribed and non-prescribed, that the patient is currently taking and are included on the plan of care.
[Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #20]

Q8: M0780, A patient is typically independent in managing her own oral medications. At the time of assessment, the patient's daughter and grandchildren have moved in to help care for the patient, and the daughter has placed the meds out of reach for safety. This now requires someone to assist the patient to retrieve the medications. How should M0780 be answered?

A8: M0780 assesses the patient's ability to prepare and take oral medications reliably and safely. Preparation includes ability to read the label (correct medication), open the container, select the pill/tablet or milliliters of liquid (correct dosage), and orally ingest at the prescribed time (take). In some cases, a patient lives in an environment where the facility or caregiver may impose a barrier that limits the patient's ability to access or prepare their medications, e.g. an Assisted Living Facility that keeps all medications in a medication room or a family that keeps the medications out of the reach of children for the child's safety - not the patient's. In these cases, the clinician will assess the patient's vision, strength and manual dexterity in the hands and fingers, as well as their cognitive status to determine the patient's ability to prepare and take their oral medications despite access barriers imposed by family or facility caregivers. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #17]

Q9: M0780, The patient with schizophrenia is not compliant with his medication regimen when he must pour his oral medications from bottles. The nurse discovers that if the pharmacist prepares the medications in bubble packs, the patient is less paranoid, is able to open the pack and will safely and reliably take the majority of his medication doses at the correct time. Since the patient is able to manage the medications once they are in the home in a bubble pack is he considered independent (Response 0) in medication management or is the special packaging requirement considered a type of assistance and is response 1 the correct answer?

A9: M0780 is asking if the patient has the ability to prepare and take oral medications reliably and safely - the correct dosage at the correct times. Preparation includes the ability to read the label (or otherwise identify the medication correctly, e.g. illiterate patients may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times. Some patients may require medications to be dispensed in bottles with easy-open lids, while others may not. Arranging to have medications dispensed in bubble packs is an excellent strategy that may enable a patient to

become independent in the management of their oral medications. Because a patient utilizes a special method or mechanism in order to take the correct medication, in the correct dose, at the correct time, does not necessarily make them dependent in the management of their oral medications. All patients are dependent on their pharmacist to dispense their medications in containers appropriate to their needs. Once in the home, if the patient requires someone else to prepare individual doses, or fill a pill box or planner, or create a diary or med list in order to take the correct med in the correct dose at the correct time, the patient would be scored a "1" indicating they require someone's else's assistance. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #18]

Q10: M0780, M0790, M0800, If a patient was in the hospital 14 days prior to the OASIS data collection time point and hospital policy prevents the patient from managing their own medications, how do you respond to the patient's prior ability to manage their oral, injectable and inhalant/mist medications?

A10: To answer the prior status items correctly, interview the patient/caregiver and determine what the patient's ability was on that particular day, despite the facility's policies or restrictions. The patient's cognitive, mental and physical condition on that particular day must be considered when determining the accurate response. Assessments of the patient's vision, strength and manual dexterity in the hands and fingers, as well as mental status will provide the necessary information to evaluate his/her ability. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #41]

Q11: M0650, M0660, M0780, For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?

The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"

A11**:** Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

Q12: M0780, If a patient can't swallow his/her meds but is able to do all the other requirements for oral medication administration, how would you answer M0780, Management of Oral Medications?

A12: M0780 reports the patient's ability to prepare and take (ingest) oral medications reliably and safely at the appropriate dosage and times. On the day of assessment, if the clinician discovers the patient has not been able to swallow prescribed oral medications in the past 24 hours, Response 2 - Unable to take medication unless administered by someone else should be selected, as it is the best response option available. The clinician should explain the patient's inability to take their oral medications in the clinical documentation and why Response 2 was selected. If it is identified that the route of administration of the medications (which may have originally been prescribed as "oral medications") had been changed to administration "per tube" due to the patient's inability to swallow, and this has been the patient's usual status on the day of assessment, then response NA - No oral medications prescribed should be selected. [Q&A added 10/07; CMS OCCB 10/07]

OASIS ITEM:

(M0790) Management of Inhalant/Mist Medications: Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

Prior	Current	
___	___	0 - Able to independently take the correct medication and proper dosage at the correct times.
___	___	1 - Able to take medication at the correct times if: (a) individual dosages are prepared in advance by another person, OR (b) given daily reminders.
___	___	2 - Unable to take medication unless administered by someone else.
___	___	NA - No inhalant/mist medications prescribed.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's ability to prepare and take all prescribed inhalant/mist medication reliably and safely and the type of assistance required to administer the current dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care - prior and current ability
Resumption of care - prior and current ability
Discharge from agency - not to an inpatient facility -- current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Exclude oral, injectable, and IV medications.
- If oxygen is included in the patient's medication regimen, consider it an inhalant medication for this item.
- "UK - Unknown" is an option only in the "prior" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient opening inhalant mist/medications and preparing any other equipment required for administration. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

Category 4B – OASIS Data Items

Q1: M0790. Is prescription nasal spray considered an inhalant medication (e.g., Flonase) for M0790? What about over the counter nasal spray (e.g., saline nasal mist)?

Answer 16: M0790 includes all prescribed and over-the-counter inhalant/mist medications included on the plan of care. Management of both the prescription Flonase and the OTC saline spray would be considered when responding to M0790. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #16]

OASIS ITEM:

(M0800) Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate time/interval. **Excludes IV medications.**

Prior	Current	
___	___	0 - Able to independently take the correct medication and proper dosage at the correct times.
___	___	1 - Able to take injectable medication at correct times if: (a) individual syringes are prepared in advance by another person, OR (b) given daily reminders.
___	___	2 - Unable to take injectable medications unless administered by someone else.
___	___	NA - No injectable medications prescribed.
___	___	UK - Unknown

DEFINITION:

Identifies the patient's ability to prepare and take all injectable mediations reliably and safely and the type of assistance required to administer the correct dosage at the appropriate time/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment - the "current" column is on what the patient is able to do today.

TIME POINTS ITEM(S) COMPLETED:

Start of care – prior and current ability
Resumption of care – prior and current ability
Follow-up – current ability
Discharge from agency – not to an inpatient facility – current ability

RESPONSE—SPECIFIC INSTRUCTIONS:

- Exclude IV medications.
- "UK - Unknown" is an option on y in the "pr or" column. This response should be used only if there is no way to determine the patient's prior ability on this item.

ASSESSMENT STRATEGIES:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

Category 4B – OASIS Data Items

Q1: M0780, M0790, M0800, If a patient was in the hospital 14 days prior to the OASIS data collection time point and hospital policy prevents the patient from managing their own medications, how do you respond to the patient's prior ability to manage their oral, injectable and inhalant/mist medications?

A1: To answer the prior status items correctly, interview the patient/caregiver and determine what the patient's ability was on that particular day, despite the facility's policies or restrictions. The patient's cognitive, mental and physical condition on that particular day must be considered when determining the accurate response. Assessments of the patient's vision, strength and manual dexterity in the hands and fingers, as well as mental status will provide the necessary information to evaluate his/her ability. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #41]

Q2: M0800, The patient has B12 injections ordered monthly which are/will be given in the home. At the SOC/ROC visit, the schedule for the injection does not fall on the day of the SOC/ROC or Discharge visit. Since our assessment should reflect what is true on the day of assessment, Is N/A, No Injectable medications prescribed the correct response to M0800 in this circumstance?

A2: The M0800 response "NA-No injectable medication prescribed" would not be appropriate in the situation described because the patient has an order to receive injectable medication during the episode. Even though the medication will not be injected on the day of the assessment, the clinician would assess and report the patient's ability by following the guidance in the Chapter 8 assessment strategies. It states "If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration." [Q&A added 01/08; CMS OCCB 01/08 Q&A #24] [Q&A EDITED 07/08]

Q3: M0800, In a previous CMS Q&A, Question 168, the answer directs that there should be no automatic assumption the patient cannot administer an injectable medication even if the physician orders the nurse to administer it. If I understand that, it means that the patient's physical and cognitive ability to administer injectable medications is assessed and used to report M0800 anytime the patient is receiving an injectable medication in the home, even if the physician is ordering administration by the nurse?

A3: The previous CMS Q&A you referenced has been recalled. If a physician orders the nurse to administer a prescribed injectable medication, the patient's ability is reported as "2- Unable to take injectable medications unless administered by someone else." The order for the nurse to administer the medication represents a medical restriction against patient selfadministration. When a patient is medically restricted from performing an activity, the impact of this medical restriction on the patient's ability must be considered. [Q&A added 01/08; CMS OCCB 01/08 Q&A #25] [Q&A EDITED 07/08]

Q4: M0800, I need more clarification regarding what is included and not included in M0800 and what are we assessing. We have a patient that is receiving injections at her physician's office, mainly for financial reasons, do we include those injections.

A4: When a patient is receiving an injectable medication in the physician's office or other setting outside the home, it is not included in the assessment of M0800, Management of Injectable

Medications. M0800, Management of Injectable Medications, reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health plan of care. M0800 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly. M0800 includes all injectable medications the patient has received or will receive in the home during the home health plan of care for the "current" status, and 14 days prior to the SOC/ROC date for the "prior" status. Note that if an injectable medication is given by a nurse, the clinician will need to determine if the administration by the nurse was for convenience, or if administration by the nurse was ordered by the physician which represents a medical restriction inferring that the patient is unsafe/unable to self-inject. If that was the case, the appropriate response for M0800 would be 2-Unable to take injectable medications unless administered by someone else. (Note this is a change from earlier guidance provided in the OASIS Web-Based Training.)

M0800 would also include one time injections that were ordered to occur in the home as long as the administration occurred during the period of time covered by the plan of care. If the patient administered the medication, the clinician would report the patient's ability to complete the included tasks on the day of the assessment. If the injection was ordered but not to be administered on the clinician's day of assessment, the clinician will use the assessment of the patient's cognitive and physical ability and make an inference regarding what the patient would be able to do. [Q&A added 04/08; CMS OCCB 01/08 Q&A #12] [Q&A EDITED 07/08]

Q5: M0800, If a patient has a "Baclofen pump infusion" does it even fall into M0800? It is being administered "intrathecally". The patient and the nurses are not doing anything with it. Everything is being done by the doctor's office. I did find the question from the web based training that states that insulin sub-q pump is considered here as well as pain meds via epidural infusion so does this fall into that category?

A5: Only medication that is injected is to be considered for M0800. Injectable medications include medications that either the patient or medical staff inject via needle and syringe subcutaneously or intramuscularly while in the home. Infusions are excluded from consideration, e.g. medications infusing via an implanted pump or external infusion device. This guidance represents a change from prior guidance found in the OASIS Web-Based Training. [Q&A added 04/08; CMS OCCB 01/08 Q&A #13] [Q&A EDITED 07/08]

Q6: M0800, We would like a clarification related to patients who draw up medication and refill an implanted pump (such as an epidural) themselves at home. For M0250 the response would be #1 as per the OASIS Manual. For M0800 would this response be 0. If a **company comes in to the home and fills the pump at home, how would we respond to M0250 and M0800? If the patient goes to a physician's office to have it filled, how would these questions be answered?**

A6: If the epidural infusion is occurring in the home, it is included in M0250, regardless of who is managing the infusion. When a patient is receiving an epidural infusion, the infusion is not considered for M0800 regardless of whether it is filled and/or infusing in the home or the office. M0800 Injectable Medications includes medications that either the patient or medical staff directly inject via needle and syringe subcutaneously or intramuscularly. Medications where the route of administration is infusion (e.g., sub-q, epidural, or IV) are not considered injectable medications, even if the medication is injected into the pump, chamber, or other external or implanted access/infusion device via a needle/syringe by the patient. [Q&A added 04/08; CMS OCCB 01/08 Q&A #14] [Q&A EDITED 07/08]

Q7: M0800. Our patient has orders for Vitamin B12 to be injected by the RN once a month and SQ Insulin to be injected by the patient 3 times a day. How would M0800 be reported in this situation?

A7: When completing M0800, Management of Injectable Medications, the clinician must consider all prescribed injectable medications that the patient is receiving in the home. In situations where the patient's ability to inject their various medications varies on the day of assessment, the clinician must report what is true in a majority of the scheduled injectable doses of medication.

In the situation described, the patient self injects insulin 3 times a day and the Vitamin B12 injection is administered by the RN only once a month. Since the order requires the nurse to administer the Vitamin B12, the patient would be considered unable to administer that medication. But, since the insulin is administered more frequently (3 times a day), the clinician should report what the patient's ability is to administer the insulin and not consider the ability to administer the once a month injection. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #17]

OASIS ITEM:

(M0810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- o 0 -Patient manages all tasks related to equipment completely independently.
- o 1 -If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.
- o 2 -Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- o 3 -Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- o 4 -Patient is completely dependent on someone else to manage all equipment.
- o NA -No equipment of this type used in care **[If NA, go to *M0826*]**

DEFINITION:

Identifies the patient's ability to set up, monitor and change equipment reliably and safely, and the amount of assistance required from another person. The focus is on what the patient is able to do, not on compliance or willingness.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Include only management of oxygen, IV infusion therapy, enteral/parenteral nutrition, and ventilator therapy equipment and supplies.
- If more than one type of equipment is used, consider the equipment for which the most assistance is needed.
- If "NA" is selected at discharge, clinician should be instructed to skip to M0830.

ASSESSMENT STRATEGIES:

Is any of the listed equipment used in care? (Note responses to M0250 and M0500 that address the specified equipment.) If so, a combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe the patient setting up and changing equipment. Ask the patient to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional assessments contribute to determining the response for this item.

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Category 4B – OASIS Data Items

Q1: M0810, I am unsure how to respond to M0810 (or M0820) if my patient has an epidural infusion of pain medication? A subcutaneous infusion?

A1: Patients receiving epidural infusions or subcutaneous infusions are receiving IV/infusion therapy, therefore, M0810 and M0820 should be answered based on the patient/caregiver ability to manage associated equipment. For M0810, the patient's ability to set up, monitor and change equipment reliably and safely, including adding appropriate fluids or medication, cleaning/storing/disposing of equipment and supplies should be assessed. NA would not be an appropriate response to M0810 in this situation. [Q&A EDITED 08/07]

Q2: M0810, Does this item include delivery devices for inhaled medications, TENS units, or mechanical compression devices?

A2: M0810 (and M0820) consider management of equipment and supplies only for oxygen, IV/infusion therapy, enteral/parenteral nutrition, and ventilator therapy and do not include the delivery devices or equipment associated with other treatments such as the type listed. (Note that inhaled medications are addressed in M0790.)

Q3: M0810 & M0820, Is C-PAP *without* oxygen or a nebulizer included as equipment for M0810 and M0820?

A3: No. If the patient's only equipment was C-PAP without oxygen or a nebulizer, the correct M0810 response would be NA – No equipment of this type used in care and M0820 would be skipped. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #42]

Q4: M0810, Is dialysis thru a central line considered for this question?

A4: Dialysis through a central line is included in M0810 as long as the dialysis occurs in the home. M0810 reports the patient's ability to manage the equipment used for the delivery of oxygen, IV/infusion therapy or enteral/parenteral nutrition. Dialysis is an infusion therapy. If the patient were receiving such therapy outside the home, (e.g. at a dialysis center), then M0810 should be marked "NA – No equipment of this type used in care", assuming the patient care did not include use of any other included services at home (oxygen, enteral nutrition, etc.). [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #31]

Q5:, M0810 & M0820, Does CPAP apply to items M0810 – Patient Management of Equipment and M0820 – Caregiver Management of Equipment?

A5: CPAP should be considered for M0810 and M0820 only if the patient is receiving oxygen via the CPAP. If the CPAP is not delivering oxygen, then it is not considered in M0810 or M0820. [Q&A added 10/07; CMS OCCB 10/07]

Q6: M0810 & M0820. When completing M0810 and M0820, Patient/Caregiver Management of Equipment, is there a consideration for people who use the larger portable oxygen tanks

versus the smaller tanks? Some of our patients use liquid oxygen and have the equipment available in the home to refill their tanks. Other patients get the larger oxygen tanks from the DME company. A person may have the ability to fill a larger tank but it is not feasible to have this equipment available in the home. The same question could apply to the various types of IV bags, equipment or solutions used for IV/infusion therapy.

A6: M0810/820, Patient/Caregiver Management of Equipment, reports the patient/caregiver's ability to set up, monitor and change the equipment that is in the home on the day of the assessment. You do not report what the patient would be able to do if different size tanks or different IV bags or solutions were available. Report the patient's ability on the day of assessment with the equipment they currently have. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #18]

OASIS ITEM:

(M0820) Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies): Caregiver's ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- 0 -Caregiver manages all tasks related to equipment completely independently.
- 1 -If someone else sets up equipment, caregiver is able to manage all other aspects.
- 2 -Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task.
- 3 -Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).
- 4 -Caregiver is completely dependent on someone else to manage all equipment.
- NA -No caregiver
- UK -Unknown

DEFINITION:

Identifies the caregiver's ability to set up, monitor and change equipment reliably and safely. The focus is on what the caregiver is able to do, not on compliance or willingness. "Caregiver" is defined in M0360.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- The definition of equipment includes only oxygen, IV/infusion equipment, enteral/parenteral nutrition and ventilator therapy equipment or supplies.
- If the patient has no caregiver, mark "NA."
- If more than one type of equipment is used, consider the equipment for which the most assistance is needed.
- At discharge, omit "UK - Unknown."

ASSESSMENT STRATEGIES:

Is any of the listed equipment used in care? (Note responses to M0250 and M0500 that address the specified equipment.) If so, a combined observation/interview approach with the caregiver is required to determine the most accurate response for this item. Observe the caregiver setting up and changing the equipment. Ask the caregiver to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional ability of the caregiver (as evaluated during the visit) contribute to determining the response for this item.

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Category 4B – OASIS Data Items

Q1: M0820, My patient has a caregiver who does everything but manage the equipment. How should I answer M0820?

A1: This item addresses only the caregiver's ability to manage the specific types of equipment listed. Thus, your response should reflect only the caregiver's ability in this particular aspect of care. The item is very circumscribed (to a specific aspect of care and to specific equipment), so your response should be confined to only these components of care delivery. The other care provided by the caregiver can be recorded in the clinical record in other areas.

Q2: M0820, Is it true that nebulizers are not considered when answering M0810 & 820 unless they are given with oxygen? M0820 Response 3 states Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment). Are nebulizers considered in these OASIS items?

A2: M0810 and M0820 are restricted to the management of oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment and supplies. A nebulizer utilizing oxygen in the treatment is considered for these items but a nebulizer without oxygen is not. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #32]

Q3: M0810 & M0820, Is C-PAP *without* oxygen or a nebulizer included as equipment for M0810 and M0820?

A3: No. If the patient's only equipment was C-PAP without oxygen or a nebulizer, the correct M0810 response would be NA – No equipment of this type used in care and M0820 would be skipped. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #42]

Q4: M0810 & M0820, Does CPAP apply to items M0810 – Patient Management of Equipment and M0820 – Caregiver Management of Equipment?

A4: CPAP should be considered for M0810 and M0820 only if the patient is receiving oxygen via the CPAP. If the CPAP is not delivering oxygen, then it is not considered in M0810 or M0820. [Q&A added 10/07; CMS OCCB 10/07]

Q5: M0810 & M0820. When completing M0810 and M0820, Patient/Caregiver Management of Equipment, is there a consideration for people who use the larger portable oxygen tanks versus the smaller tanks? Some of our patients use liquid oxygen and have the equipment available in the home to refill their tanks. Other patients get the larger oxygen tanks from the DME company. A person may have the ability to fill a larger tank but it is not feasible to have this equipment available in the home. The same question could apply to the various types of IV bags, equipment or solutions used for IV/infusion therapy.

A5: M0810/820, Patient/Caregiver Management of Equipment, reports the patient/caregiver's ability to set up, monitor and change the equipment that is in the home on the day of the assessment. You do not report what the patient would be able to do if different size tanks or different IV bags or

solutions were available. Report the patient's ability on the day of assessment with the equipment they currently have. [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #18]

OASIS ITEM:

(M0826) **Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(__ __ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

o NA -Not Applicable: No case mix group defined by this assessment.

DEFINITION:

Identifies the total number of therapy visits (physical, occupational or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group. Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the treatment of the patient's illness or injury.

TIME POINTS ITEM(S) COMPLETED:

Start of care Resumption of care Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS:

- Answer "000" if no therapy services are needed.
- Answer "Not Applicable" when this assessment will not be used to determine a Medicare case mix group. Usually, the "Not Applicable" response will be checked for patients whose payment source is not Medicare fee-for-service (i.e., M0150, Response 1 is not checked), or for an assessment that will not be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response to this item is required to generate the case mix code.

ASSESSMENT STRATEGIES:

When the patient assessment and the care plan are complete, review the plan to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services are ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
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Q1: M0110 & M0826, If we determine that we answered M0826, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take?

A1: In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at: http://www.cms.hhs.gov/center/hha.asp it states:
"The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M0826) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available."

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient's medical record, if it comes to the clinician's attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected following the agency's correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the State system. For example, if the clinician chose "Early" and during the episode, s/he learned that the patient was in a "Later" episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M0826 that will be required in the upcoming episode. Because M0826 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M0826 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M0826. [Q&A added 10/07; CMS OCCB 10/07]

Q2: M0110 & M0826, How would an agency report M0110 and M0826 when the patient has a HMO/MCO insurance (and is managed by Medicare) when they require a HIPPS code? What if they *don't* require a HIPPS Code?

A2: If the payer requires an HHRG/HIPPS, M0110 should be answered Early, Later or Unknown and M0826 should reflect the number of reasonable and necessary therapy visits planned for the episode. If the payer does not need the HHRG/HIPPS, M0110 and M0826 should be answered NA. The agency will need to communicate with their non-Medicare Traditional Fee-for-Service (PPS) patient's payer to determine if they require a HHRG/HIPPS. [Q&A added 01/08; CMS OCCB 01/08 Q&A #12

Q3: M0826, We are having a huge discussion as to what the meaning of the new M0826 question implies. At present if the admission is done by nursing any rehabilitation service is put on the 485 (plan of care) as a 1 day 1 for evaluation and treatment. Then later the

rehabilitation service enters their own orders and frequency as a verbal order after they have completed therapy evaluation. The way the new M0826 reads, some feel the nurse must put on the 485 a total of rehabilitation visits to match the OASIS number placed in the blank even though the rehabilitation service may or may not have made their evaluation visit to the patient by the time the POT and OASIS are to be completed. We realize CMS will adjust the actual number of visits later as the claim is processed but are we expected to put the guess on the 485 at the start of care? Is this a compliance issue?

A3: Chapter 8 of the OASIS User's manual, on page 8.112, states under the Definition "Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the treatment of the patient's illness or injury." It further states under Assessment Strategies "If the number of visits that will be needed is uncertain, provide your best estimate." [Q&A added 01/08; CMS OCCB 01/08 Q&A #26] [Q&A EDITED 07/08]

Q4: M0826, I am entering an assessment into HAVEN using the B1-0108 form. I do not require a HIPPS code how should I complete M0826 to not receive a HIPPS Code?

A4: If a HIPPS Code is not required you may leave 'Number of Therapy Visits' blank and check 'Not Applicable'. Note: If 'Not Applicable' is checked then 'Number of Therapy Visits' must be blank. [Q&A added 01/08; CMS OCCB 01/08 Q&A #27] [Q&A EDITED 07/08]

Q5: M0826, Following the instructions for Therapy Need for the OASIS B-1 (1/2008), when adding the number of therapy visits, must a "0" be placed before the number or will values less than 100 be recognized without "0" preceding them? For example, if you project 11 visits, should you put 011 or just 11?

A5: If M0826 Therapy Need is not marked N/A, then the 1.60 OASIS Data Specs require that M0826 must report a number that is "zero filled and right justified". The number of therapy visits entered into M0826 must range from 000 to 999. If there are less than 3 digits in the number the therapy visits to report, the number must be preceded by zeros. For example, "11" visits should be entered as "011". [Q&A added 01/08; CMS OCCB 01/08 Q&A #28] [Q&A EDITED 07/08]

Q6: M0826, I am uncertain how to answer M0826 in the following situations, please clarify:

a. At ROC?

b. When patient has multiple payers and some therapy services are covered under the Medicare home health benefit and other therapy services are not (e.g. patient in a long term home health care program (LTHHCP) or one who pays privately for therapy beyond what is considered reasonable and necessary)?

c. When I add therapy services mid-episode?

A6:

a. At ROC M0826 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4), data from M0826 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, 0826 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not needed for payment, response NA – Not applicable: No case mix group defined by this assessment could e reported on M0826. Alternatively, roviders may choose to report the total of therapy visits that have been provided during the episode to date, added to the number of therapy visits planned to be provided

during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses. While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60 day episode should be reported.

b. Therapy services that are not covered by the Medicare HH benefit: M0826 should reflect the total number of reasonable and necessary therapy visits (e.g. therapy visits that meet the Medicare home health coverage criteria) that the agency plans to provide during the payment episode. If the agency intends on providing therapy visits that do not meet the Medicare home health coverage criteria (e.g. more frequent than necessary, custodial or repetitive in nature), including those which the agency intends to bill to another (non Medicare PPS) payer, only those visits that meet the Medicare home health benefit coverage should be reported in M0826.

c. Therapy services added mid-episode: When therapy services are ordered within the episode, the RFA 5 (other follow up) assessment may be required, depending on your agency's established policy and practice. The number of visits reported in M0826 on the RFA 5 assessment will in no way impact the episode payment under Medicare PPS. Upon submission if the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the actual number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M0826. The agency does not have to go back and make any changes or corrections to M0826 at the SOC or other time points. [Q&A added 04/08; CMS OCCB 01/08 Q&A #15] [Q&A EDITED 07/08]

OASIS ITEM:

(M0830) **Emergent Care:** Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply.)**

- o 0 -No emergent care services **[If no emergent care, go to M0855]**
- o 1 -Hospital emergency room (includes 23-hour holding)
- o 2 -Doctor's office emergency visit/house call
- o 3 -Outpatient department/clinic emergency (includes urgicenter sites)
- o UK -Unknown **[If UK, go to M0855]**

DEFINITION:

Identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care agency services. Emergent care services include all unscheduled visits occurring within 24 hours of the time the patient has contacted the medical services. A “prn” agency visit is not considered emergent care.

TIME POINTS ITEM(S) COMPLETED:

Transfer to an inpatient facility - with or without agency discharge Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS:

- If a patient went to the ER, was “held” at the hospital for observation, then released, the patient did receive emergent care. The time period that a patient can be "held" without admission can vary. "Holds" can be longer than 23 hours but emergent care should be reported regardless of the length of the observation "hold." It should be verified that the patient was not actually admitted to the inpatient facility; if such an admission occurred, then a transfer assessment is required in addition to the emergent care.
- Exclude outpatient visits for scheduled diagnostic testing.
- Responses to this item include the entire period since the last time OASIS data were collected, including current events. A patient who goes to the ER, then is admitted to the hospital, should be noted as having received emergent care.
- A patient who dies in the ER is considered to have been under the care of the emergency room, not the home health agency. In this situation, a transfer assessment, not an assessment for "Death at Home," should be completed.

ASSESSMENT STRATEGIES:

Ask the patient/caregiver if the patient has had any services for emergent care. Clarify that a doctor’s office visit which is scheduled less than 24 hours in advance is considered an emergent care visit.

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Category 4B – OASIS Data Items

Q1: M0830, When I called to schedule my visit, I learned that my patient was seen in the ER and was then admitted to the hospital. How should I answer M0830?

A1: Emergent care includes all unscheduled visits to medical services occurring within 24 hours of the patient's contact with the medical service, as noted in the response options, including a hospital emergency room. Since the patient was admitted to the hospital following the emergency room visit, (and assuming the patient stayed for 24 hours or more for reasons other than diagnostic testing) a Transfer to the inpatient facility (RFA 6 or 7 to M0100) would be required. You should mark M0830 with response 1 - Hospital emergency room. [Q&A EDITED 08/07]

Q2: M0830, The patient was held in the ER suite for observation for 36 hours. Was this a hospital admission or emergent care?

A2: If the patient were never admitted to the inpatient facility, this encounter would be considered emergent care. The time period that a patient can be 'held' without admission can vary from location to location, so the clinician will want to verify that the patient was never actually admitted to the hospital as an inpatient. [Q&A EDITED 08/07]

Q3: M0830, The patient had a planned visit for cataract surgery at the outpatient surgical center. Is this emergent care?

A3: Emergent care is defined as all unscheduled visits (to an emergency room, doctor's office or outpatient clinic) occurring within 24 hours of the patient contact to the medical service. The situation you described was a planned visit and thus is not considered emergent care. [Q&A EDITED 08/07]

Q4: M0830, If the patient receives a home visit from a nurse practitioner from the doctor's office in response to a fall, or increased pain, or other problematic symptoms, would this be considered emergent care?

A4: Yes, as long as the visit occurred within 24 hours of being scheduled, the (non-home care) nurse's home visit would be considered emergent care and would be reported based on the entity (hospital, doctor's office, outpatient clinic) that sent the nurse. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #22] [Q&A EDITED 08/07]

Q5: M0830, Should all unscheduled MD visits be considered emergent care for purposes of responding to M0830? Or only those which the clinician judges to represent an MD visit being utilized in lieu of an emergency room visit? For instance, if the clinician calls the physician with patient reports of marked calf pain, tenderness, and acute SOB and the physician wants the patient to come into his office, would that be considered emergent care? If the clinician calls the physician to report that the patient's knee range of motion is not progressing as rapidly as expected and the doctor tells the patient to move up their appointment by a few days and come in today; would that be considered emergent care?

A5: In M0830 Emergent Care, we are trying to determine if the patient received emergent medical care for an illness or injury since the last time an assessment was completed.

"Emergent/unscheduled (within 24 hours) care is the definition that we are using and following. CMS has not changed the definition of M0830. It remains the same as the current manual. The clinician needs to use the information for any necessary care planning changes; for example, was there a change or addition in medications or treatments? The item does not justify "why" the patient sought emergent care, only that emergent care occurred (or not). The "24 hour" timeframe is a guideline to see if the need for the physician visit was emergent or not. If a patient is listed on an adverse event report, then the agency needs to investigate the event to determine whether or not the care for this patient was problematic. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A 23]

Q6: M0830, Please clarify responding to the patient who dies in the ER (before being formally admitted to the inpatient facility) and for the patient who is pronounced "dead on arrival" in ER.

A6: When a patient dies in the emergency room it is NOT considered a death at home. When a patient dies in the emergency room, a transfer assessment should be completed, and "Response 1 – Hospital emergency room" should be reported for M0830. This is true even though the patient was never formally admitted to the inpatient facility, because the facility was actively providing care at the time of the patient's death. The patient who is pronounced "dead on arrival" by the ER physician on arrival at the ER should be reported as a "death at home" and RFA 8 OASIS data collection would be required.. (The RFA Death at Home assessment items do not include collection of M0830.) [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #9 & 10] [Q&A EDITED 08/07]

Q7: M0830, If a patient is admitted to an inpatient facility after initial access in the emergency room, can there be a situation in which that emergent care would NOT be reported on M0830, (i.e., patient is only briefly triaged in ER with immediate and direct admit to the hospital)?

A7: The item-by-item response specific instructions in Chapter 8 of the Implementation Manual clarify that responses to M0830 – Emergent Care, include the entire period since the last time OASIS data were collected, including current events. Any access of emergent care, regardless of how brief the encounter, should be reported on M0830 if it occurred since the last time OASIS data were collected. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #11]

Q8: M00830, A patient whose Start of Care is January 9, has an emergent care visit on January 13 that does not result in hospitalization. The patient is subsequently recertified and discharged on March 17. M0830, which appears on the transfer and discharge assessments, specifies the response should be based on the "last time OASIS data was collected." Should the response to M0830 regarding emergent care be based on the last time any OASIS assessment was completed, or should it be based on the last assessment where M0830 appears. In this scenario, the item is being asked at the time of discharge where the recertification OASIS was "the last time OASIS data was collected." Since the emergent care visit occurred before the recertification, it would not have been identified at that time because it is not a required item.

A8: The above scenario does not tell us when recertification assessment was completed. According to the Conditions of Participation for HHA, the recertification visit should have occurred during a five-day period prior to the end of the episode, which should be March 5-9. The OASIS item (M0830) Emergent Care asks for responses to include the entire period since the last time OASIS data were collected, including current events. Since the last time OASIS data were collected was at the recertification assessment, the emergent care visit occurred prior to that date.

The correct response to M0830 is 0-no emergent care services were provided. [Q&A added 06/05]

Q9: M0830, Is M0830 limited to the service sites specifically listed in the OASIS responses? What if a patient was a direct admit to the hospital unit, without passing through the emergency room?

A9: M0830 identifies whether the patient received an unscheduled visit to any of the following services; hospital emergency room, doctor's office/house call, or outpatient department or emergency clinic. A direct admit to a hospital unit would not be reported as emergent care on M0830. This situation would, however, be considered a transfer to an inpatient facility, as long as the admission lasted 24 hours or longer for reasons other than diagnostic testing, and would be considered an "emergent" reason for hospital admission in responding to M0890. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #13]

Q10: M0830, We have a rather large physician's practice in our area where no appointments are scheduled in advanced. The patients needing to be seen simply are instructed to show up and are seen by the physician's on a first-come, first-served basis. Since all these appointments are "unscheduled", would all of these doctor's visits need to be reported as emergent care by the MD on M0830?

A10: Since the determination of an MD emergent care visits is defined as a visit to/from the MD scheduled less than 24 hours in advance, then the patient's visits to the MD scheduled and provided as you describe would all meet the definition of being scheduled less than 24 hours in advance, and should be reported as emergent care Response 2 for M0830 – Emergent Care. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #45]

Q11: M0830, My patient had a fall at home. The family called 911. The ambulance arrived and the patient was evaluated by the EMTs but not transported from the home. Is this considered emergent care for M0830, and if so what response should be marked?

A11: M0830 reports the patient's use of emergent care by/from 3 distinct settings/providers, the hospital emergency department, the physician's office, and the outpatient clinic/urgicenter. Services from the ambulance staff are not included in the providers reported in M0830. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #46]

Q12: M0830, An RN completes a SOC assessment and establishes the plan of care. After the admission visit, subsequent care is provided by the LPN and home health aide for a period of 2 weeks, during which time the patient is seen in the ER. The physician contacts the agency to discontinue home care without an opportunity to complete a discharge assessment visit. Based on current guidance, in this case of an unexpected discharge, the discharge comprehensive assessment would be based on the last visit by a qualified clinician (which was the SOC assessment by the RN.) Since it should reflect the patient's status on that SOC visit, should the emergent care use be captured, since it occurred after the SOC visit?

A12: No, in the case of an unexpected discharge, the agency must go back to the last visit that was completed by a qualified clinician, and report the patient's health status at that actual visit, and would not capture events or changes in patient status/function (improvements or declines) that occurred after the last visit conducted by a qualified clinician. Agencies should recognize that the practice of allowing long periods of time where the patient's care is provided by those unable to conduct a comprehensive assessment may negatively impact the patient's care and outcomes,

and in fact, in a situation as the one described, may be the reason that the patient required emergent care.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #47]

Q13: M0100 & M0830, Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a "Patient Observation" or "PO" bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?

A13: For purposes of OASIS (M0830) Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M0830. If from observation status the patient is eventually admitted to the hospital as an inpatient (assuming the transfer criteria are met), then this would trigger the Transfer OASIS assessment, and the agency would complete RFA 6 or RFA 7 data collection, depending on whether the agency chose to place the patient on hold or discharge from home care.

During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence. Outpatient therapy services provided during the period of observation would be included under consolidated billing and should be managed as such. The HHA should always inform the patient of consolidated billing at the time of admission to avoid non-payment of services to the outpatient facility. If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified plan of care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria. The home health agency would bill for this patient as they would for any patient who was seen in an emergency room and returned home without admission to the inpatient facility following guidance in the Medicare Claims Processing manual.

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

Q14: M0100 & M0830, Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a "Patient Observation" or "PO" bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?

A14: For purposes of OASIS (M0830) Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M0830. If from observation status the patient is eventually admitted to the hospital as an inpatient (assuming the transfer criteria are met), then this would trigger the Transfer OASIS assessment, and the agency would complete RFA 6 or RFA 7 data collection, depending on whether the agency chose to place the patient on hold or discharge from home care. During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence. Outpatient therapy services provided during the period of observation would be included under consolidated billing and should be managed as such. The HHA should always inform the patient of consolidated billing at the time of admission to avoid non-payment of services to the outpatient facility. If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified plan of care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria. The home health agency would bill for this patient as they would for any patient who was seen in an emergency room and returned home without admission to the inpatient facility following guidance in the Medicare Claims Processing manual.

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

OASIS ITEM:

(M0840) Emergent Care Reason: For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**

- o 1 -Improper medication administration, medication side effects, toxicity, anaphylaxis
- o 2 -Nausea, dehydration, malnutrition, constipation, impaction
- o 3 -Injury caused by fall or accident at home
- o 4 -Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- o 5 -Wound infection, deteriorating wound status, new lesion/ulcer
- o 6 -Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- o 7 -Hypo/Hyperglycemia, diabetes out of control
- o 8 -GI bleeding, obstruction
- o 9 -Other than above reasons
- o UK -Reason unknown

DEFINITION:

Identifies the reasons for which the patient/family sought emergent care.

TIME POINTS ITEM(S) COMPLETED:

Transfer to an inpatient facility - with or without agency discharge Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS:

- If more than one reason contributed to the emergent care visit, mark all appropriate responses. For example, if a patient sought care for a fall at home and was found to have medication side effects, mark both responses.
- If the reason is not included in the choices, mark Response 9 - Other than above reasons.

ASSESSMENT STRATEGIES:

Ask the patient/caregiver to state all the symptoms and reasons for which they sought emergent care. A phone call to the doctor's office or emergency room may be required to clarify the reasons for emergent care.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
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Category 4B – OASIS Data Items

Q1 M0840, I have a question about how to complete a Transfer OASIS when a client has a fall outside of the home. If they go to the doctor's office for care and falls there, should the answer to M0840 – Emergent Care Reason be #3 – Injury caused by fall or accident at home or #9 – Other than above reason (since the fall/accident did not occur in the home)?

A1 M0840 Response 3 would be selected for an injury caused by a fall or accident at home. If a patient sought emergent care for an injury that occurred while away from home, the correct response to M0840 would be 9-Other than above reasons. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #19]

Q2: M0840. A patient went to an urgent care center (M0830) because of worsening oral thrush symptoms with increased (new) oral lesions. Would M0840 – Emergent Care Reason be marked as "*5 - Wound infection, deteriorating wound status, new lesion/ulcer*"? M0440 - refers only to lesions to the integumentary system; is that also true for M0840?

A2: M0840, Response 5, would report emergent care of any wound infection, deteriorating wound status or new lesion or ulcer, (e.g. skin, eyes, oral cavity, nasal, vaginal, rectal). [Q&A ADDED 08/08; CMS OCCB 07/08 Q&A #19]

OASIS ITEM:

(M0855) To which **Inpatient Facility** has the patient been admitted?

- o 1 -Hospital **[Go to *M0890*]**
- o 2 –Rehabilitation facility **[Go to *M0903*]**
- o 3 -Nursing home **[Go to *M0900*]**
- o 4 -Hospice **[Go to *M0903*]**
- o NA -No inpatient facility admission

DEFINITION:

Identifies the type of inpatient facility to which the patient was admitted.

TIME POINTS ITEM(S) COMPLETED:

Transfer to inpatient facility - with or without agency discharge Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Admission to a freestanding rehabilitation hospital or a rehabilitation distinct part unit of a general acute care hospital is considered a rehabilitation facility admission.
- Admission to a skilled nursing facility (SNF), an intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility (NF) is a nursing home admission.
- At inpatient transfer, omit "NA."

ASSESSMENT STRATEGIES:

Often the family or medical service provider informs the agency that the patient has been admitted to an inpatient facility. Clarify with this informant as to which type facility the patient has been admitted. As a last resort, you may have to contact the facility to determine how it is licensed.

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Category 4B – OASIS Data Items

Q1: M0855, For M0855 are 'Rehabilitation Facility' and 'Nursing Home' both considered skilled nursing facilities?

A1: For M0855, response 2, 'rehabilitation facility' is a certified, distinct rehabilitation unit of a nursing home OR a freestanding rehabilitation hospital. For response 3, 'nursing home' includes either a skilled nursing facility or an intermediate care facility.

Q2: M0855, A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care units. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M0855?

A2: Yes, if the patient was admitted to an inpatient facility, the agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M0855. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed(response 1 would apply) or a nursing home bed (response 3 would apply). The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized. [Q&A added 06/05]

Q3: M0855, When a patient is transferred to a hospital ER and dies while in the ER, I understand a Transfer OASIS would be completed and not a Death at Home OASIS. At M0855, on a Transfer OASIS there are 4 options. There is no N/A option, as there would be on a Discharge OASIS. It does not seem appropriate to select Option 1 (hospital) since the patient was not admitted to the hospital, but we cannot transmit the OASIS without entering some response.

A3: When a patient dies in the ER, the Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to mark Response “1-Hospital” for M0855, even though the patient was not admitted to the inpatient facility. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #35]

Q4: M0100 & M0855, HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under “observation status”). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e. no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a hospitalization? How do you answer M0100 & M0855?

A4: In order to qualify for the Transfer to Inpatient Facility OASIS assessment time point, the

patient must meet 3 criteria:
1) Be admitted to the inpatient facility (not the ER, not an observation bed in the ER)
2) Reside as an inpatient for 24 hours or longer (does not include time spent in the ER)
3) Be admitted for reasons other than diagnostic testing only

In your scenario, you are describing a patient that is admitted to the inpatient facility, and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a hospitalization. The correct M0100 response would be either 6-Transfer to an Inpatient Facility, patient not discharged or 7Transfer to an Inpatient Facility, patient discharged, depending on agency policy. M0855 would be answered with Response 1-Hospital as you state the patient was admitted to a hospital. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #10]

OASIS ITEM:

(M0870) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- o 1 -Patient remained in the community (not in hospital, nursing home, or rehab facility)
- o 2 -Patient transferred to a noninstitutional hospice **[Go to *M0903*]**
- o 3 -Unknown because patient moved to a geographic location not served by this agency **[Go to *M0903*]**
- o UK -Other unknown **[Go to *M0903*]**

DEFINITION:

Identifies where the patient resides after discharge from the home health agency.

TIME POINTS ITEM(S) COMPLETED:

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Patients who are in assisted living or board and care housing are considered to be living in the community.
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not an inpatient hospice facility.

ASSESSMENT STRATEGIES:

At agency discharge, determine where the patient will be living/residing.

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Category 4B – OASIS Data Items

Q1: M0870, My patient was admitted to the hospital, and I completed the assessment information for Transfer to the Inpatient Facility. His family informed me that he will be going to a nursing home rather than returning home, so my agency will discharge him. How should I complete these items on the discharge assessment?

A1: Once the transfer information was completed for this patient, no additional OASIS data would be required. Your agency will complete a discharge summary that reports what happened to the patient for the agency clinical record; however, no discharge OASIS assessment is required in this case. The principle that applies to this situation is that the patient has not been under the care of your agency since the inpatient facility admission. Because the agency has not had responsibility for the patient, no additional assessments or OASIS data are necessary.

OASIS ITEM:

(M0880) After discharge, does the patient receive health, personal, or support **Services or Assistance**? **(Mark all that apply.)**

- o 1 -No assistance or services received
- o 2 -Yes, assistance or services provided by family or friends
- o 3 -Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care) **Go to M0903**

DEFINITION:

Identifies services or assistance a patient receives after discharge from the home health agency.

TIME POINTS ITEM(S) COMPLETED:

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

• Assistance or services in Responses 2 or 3 may be paid or unpaid.

ASSESSMENT STRATEGIES:

Ask the patient/caregiver what type of services or support the patient might be receiving after discharge. M0380 contains a list of services or assistance that can be used as a reference. Include services which the agency may have arranged or personal care/chore services that the agency may continue to provide after discharge from skilled care services.

CMS OASIS QUESTIONS AND ANSWERS REVISED 8/08
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Category 4B – OASIS Data Items

Q1: M0880, How would outpatient therapy services be categorized?

A1: Response option 3 - assistance or services provided by other community resources is an appropriate response in this situation.

Q2: M0880, What if my patient is being discharged from a payer source in order to begin care under a new payer source?

A2: The OASIS items do not request a reason for discharge, only whether the patient is continuing to receive services if he/she remains in the community. In this situation, the appropriate response for M0870 would be 1 - Patient remained in the community, and the correct response for M0880 would be 3 - Yes, assistance or services provided by other community resources.

OASIS ITEM:

(M0890) If the patient was admitted to an acute care **Hospital**, for what **Reason** was he/she admitted?

- o 1 -Hospitalization for emergent (unscheduled) care
- o 2 -Hospitalization for urgent (scheduled within 24 hours of admission) care
- o 3 -Hospitalization for elective (scheduled more than 24 hours before admission) care
- o UK -Unknown

DEFINITION:

Identifies the urgency of the hospital admission.

TIME POINTS ITEM(S) COMPLETED:

Transfer to inpatient facility - with or without agency discharge

RESPONSE—SPECIFIC INSTRUCTIONS:

- A patient hospitalized immediately subsequent to a doctor's office, outpatient clinic, or ER visit has been hospitalized for emergent care.
- A hospitalization that is scheduled is either urgent or elective depending on whether there were more than 24 hours between the scheduling and the actual admission.

ASSESSMENT STRATEGIES:

Interview the patient, family, or medical service provider to determine whether the acute hospitalization was related to emergent, urgent, or elective care.

Category 4B – OASIS Data Items

Q1: M0890, What if M0830 was already answered "yes?" How should I answer this item?

A1: You should respond to M0890 appropriately for the situation. M0830 might have been answered "yes" for a separate instance of emergent care, not necessarily relating to this hospitalization. If the patient was hospitalized after having been seen in the emergency room, then M0830 would be answered "yes," and M0890 would most likely be answered with response 1 - Hospitalization for emergent (unscheduled) care.

OASIS ITEM:

(M0895) Reason for Hospitalization: (Mark all that apply.)

- o 1 -Improper medication administration, medication side effects, toxicity, anaphylaxis
- o 2 -Injury caused by fall or accident at home
- o 3 -Respiratory problems (SOB, infection, obstruction)
- o 4 -Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- o 5 -Hypo/Hyperglycemia, diabetes out of control
- o 6 -GI bleeding, obstruction
- o 7 -Exacerbation of CHF, fluid overload, heart failure
- o 8 -Myocardial infarction, stroke
- o 9 -Chemotherapy
- o 10 -Scheduled surgical procedure
- o 11 -Urinary tract infection
- o 12 -IV catheter-related infection
- o 13 -Deep vein thrombosis, pulmonary embolus
- o 14 -Uncontrolled pain
- o 15 -Psychotic episode
- o 16 -Other than above reasons **Go to M0903**

DEFINITION:

Identifies the specific condition(s) necessitating hospitalization.

TIME POINTS ITEM(S) COMPLETED:

Transfer to inpatient facility - with or without agency discharge

RESPONSE—SPECIFIC INSTRUCTIONS:

- Mark all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 15 would be marked.

ASSESSMENT STRATEGIES:

Interview the patient, family, or medical service provider to determine the condition requiring acute hospital admission.

OASIS ITEM:

(M0900) For what **Reason(s)** was the patient **Admitted** to a **Nursing Home**? **(Mark all that apply.)**

- o 1 -Therapy services
- o 2 -Respite care
- o 3 -Hospice care
- o 4 -Permanent placement
- o 5 -Unsafe for care at home
- o 6 -Other
- o UK -Unknown

DEFINITION:

Identifies the reason(s) the patient was admitted to a nursing home.

TIME POINTS ITEM(S) COMPLETED:

Transfer to inpatient facility - with or without agency discharge

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Interview the patient, family, or medical service provider to determine the reason(s) for nursing home placement. Often the agency clinician will have assessed conditions for which nursing home placement is necessary or appropriate.

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OASIS ITEM:

(M0903) Date of Last (Most Recent) Home Visit:

__ __ /__ __ / __ __ __ __
month day year

DEFINITION:

Identifies the last or most recent home visit of any agency provider, including skilled providers or home health aides.

TIME POINTS ITEM(S) COMPLETED:

Transfer to an inpatient facility - with or without agency discharge
Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits of the year.

ASSESSMENT STRATEGIES:

When more than one agency staff member is providing care, refer to agency clinical record for date of last visit. If today's visit is the last (discharge) visit, enter today's date.

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Category 4B – OASIS Data Items

Q1: M0903, Do the dates in M0903 and M0090 always need to be the same? What situations might cause them to differ?

A1: When a patient is discharged from the agency with goals met, the date of the assessment (M0090) and the date of the last home visit (M0903) are likely to be the same. Under three situations, however, these dates are likely to be different. These situations are: (1) transfer to an inpatient facility; (2) patient death at home; and (3) the situation of an "unexpected discharge." In these situations, the M0090 date is the date the agency learns of the event and completes the required assessment, which is not necessarily associated with a home visit. M0903 must be the date of an actual home visit. See the *OASIS User's Manual,* Chapter 4, for additional information on "unexpected discharges." [Q&A EDITED 08/07]

Q2: M0903, What constitutes a "home visit" when responding to OASIS Item M0903? Medicaid programs pay for some home health services provided outside of the home. If these patients receive all their skilled care outside the home, must OASIS data be collected and transmitted? If some of the visits are provided outside of the home should a visit provided outside the home be considered the last visit for M0903, or should M0903 be the last visit at the patient's home?

A2: The date of the last (most recent) home visit (for responding to M0903) is the last visit occurring under the plan of treatment. The HHA must conduct the comprehensive assessment and collect and transmit OASIS items for Medicaid patients receiving skilled care. [Q&A added 06/05]

Q3: M0903 & M0906, When a speech therapist is the last service in a patient's home, our agency has chosen to use an RN to complete the discharge assessment (with OASIS) as a non-billable visit. If the patient meets the speech therapist's goals on day 50 of the episode, but we cannot schedule an RN until day 51 of the episode, how do we respond to M0903 and M0906?

A3: If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the SLP. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. M0903 (Date of Last/Most Recent Home Visit) would be the date of the last visit by the agency; in this case it would be the date of the RN visit. The date for M0906 (Discharge/Transfer/Death Date) would be determined by agency policy. The date of the actual agency discharge date would be entered here. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906 (Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted. [Q&A added 06/05]

OASIS ITEM:

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

__ __ /__ __ / __ __ __ __
month day year

DEFINITION:

Identifies the actual date of discharge, transfer, or death (at home).

TIME POINTS ITEM(S) COMPLETED:

Transfer to an inpatient facility - with or without agency discharge Death at home Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- The date of discharge is determined by agency policy or physician order.
- The transfer date is the actual date the patient was transferred to an inpatient facility.
- The death date is the actual date of the patient's death at home. Exclude death occurring in an inpatient facility. Include death which occurs while a patient is being transported to an inpatient facility (before being admitted).

ASSESSMENT STRATEGIES:

Agency policy or physician order may establish discharge date. Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.

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Category 4B – OASIS Data Items

Q1: M0906, My patient died at home 12/01 after the last visit of 11/30. I did not learn of her death until 12/04. How do I complete M0903 and M0906? What about M0090?

A1: You will complete an agency discharge for the reason of death at home (RFA 8 for M0100). M0090 would be 12/04 -- the date you learned of her death and completed the assessment. M0903 (date of last home visit) would be 11/30, and M0906 (death date) would be 12/01. [Q&A EDITED 08/07]

Q2: M0906, How do you answer M0906 on a Transfer OASIS when a patient is transferred to an inpatient facility (hospital) during the evening of 1/24/07 but doesn't get admitted to the inpatient facility until 1/25/07?

A2: Transfer is not defined as the date the patient was transported to the inpatient facility, or the date that the patient was transported and/or treated in the emergency department. Assuming the patient's inpatient admission lasted 24 or more hours, and included care/services other than diagnostic testing, the Transfer date would be the actual date the patient was admitted to the inpatient facility. If, as in your example, the transportation occurred during the evening of 1/24/07, but the inpatient facility admission did not occur until 1/25/07, M0906 Transfer/Discharge/Death Date would be 1/25/07. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #36]

Change Page
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Page(s)	Change
8.5	Table 8.1 "PostVisit" section updated to delete Item M0245 from *Primary diagnosis and comorbidities* row and Item M0825 changed to reflect new Item M0826 in *Need for physical, occupational, or speech therapy* row
8.9	Point number 3 updated to indicate current version of OASIS, 01/2008
8.18	Item M0030, definition language updated to include "reimburseable care," additional clarification provided in response-specific instructions
8.31	Item M0100, follow-up time point skip pattern revised to indicate new "Go to M0110" instructions
8.33	New OASIS item M0110
8.38	M0175, follow-up time point deleted from Time Points Item(s) Completed section and skip instruction changed
8.40	M0190, bullet points revised in Response—Specific Instructions
8.41	M0200, "no" option skip pattern revised to include "if No at Discharge, go to M0250."
8.42	M0210, bullet points revised in Response—Specific Instructions
8.43	M0220, asterisks removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.44 - 8.46	OASIS items M0230/M0240/M0246 replace M0230/M0240 and updated instructions given
8.54	M0350, asterisks removed from OASIS item and moved to become bullet points in Response—Specific Instructions
8.55	M0360, asterisks removed from OASIS item and moved to become bullet points in Response—Specific Instructions
8.56	M0370, asterisk removed from OASIS item and moved to become

	bullet point in Response—Specific Instructions
8.57	M0380, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.65 - 8.66	M0450, text has been revised in bullet point #4 of the Response-Specific Instructions and in the Assessment Strategies
8.67	M0460, OASIS item title has been revised to include "At Follow-up, skip to M0470 if patient has no pressure ulcers." Text has been revised in the Definition and in the Response-Specific Instructions
8.68	M0464, text has been revised in the Response-Specific Instructions
8.70	M0470, follow-up time point added to Time Points Item(s) Completed section
8.71	M0474, follow-up time point added to Time Points Item(s) Completed section
8.72	M0476, OASIS item title has been revised to include "At Follow-up, skip to M0488 if patient has no stasis ulcers."
8.76	M0488, OASIS item title has been revised to include "At Follow-up, skip to M0490 if patient has no surgical wound(s)."
8.79	M0510, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.80	M0520, follow-up time point added to Time Points Item(s) Completed section
8.81	M0530, asterisk information removed from OASIS item
8.82	M0540, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.83	M0550, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions
8.89	M0610 follow-up time point deleted from Time Points Item(s) Completed section
8.109	M0800 follow-up time point added to Time Points Item(s) Completed section

8.110 M0810, skip instruction for NA response changed to M0826. Asterisk information removed from OASIS item

8.111 M0820, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions

8.112 Item M0826 and new instructions replace Item M0825

8.115 M0855, asterisk removed from OASIS item and moved to become bullet point in Response—Specific Instructions

Home Health Quality Initiatives

OASIS OBQM

Adverse Event Outcome - OBQM - Outcome Based Quality Management

One of the new publicly reported measures is known to home health agencies as an adverse event. The Agency Adverse Event Outcome Report, displays incidence rates for **infrequent** untoward events (outcomes) comparing the agency to a reference sample.

The Quality Measure 'Emergent Care for New, Infected, or Deteriorating Wound/Lesion' will be based on the average for all episodes of care that end within a one-year period for this Outcome Based Quality Measure. The state and national rates are aggregated directly from patient-level data, which is equivalent to using the exact agency rates weighted by the number of cases for each agency.

Adverse Events are not currently risk adjusted, as explained in the OBQM manual, page 3.1. In the past because these numbers were so small the risk

adjustment model was not applied, CMS will explore and work with our researchers to determine the feasibility to do so.

High-priority adverse event outcomes are: **(a)** those with the most clinical relevance to the agency, and **(b)** those with the highest incidence as compared to the reference group. (**Statistically Significant**) An "ideal" adverse event outcome for early investigation will meet both of these criteria.

Adverse events serve as markers for potential problems in care because of their negative nature and relatively low frequency. It is important to emphasize the word ***potential*** in this definition. Whether or not an individual patient situation results from inadequate care provision can only be determined through investigation of the care actually provided to specific patients.

A home health agency's ability to improve or maintain the health of their patients partly depends on a partnership with the discharging and community physician, the ability and willingness of patients and their families to help themselves and follow the orders and treatment prescribed, even when the home health staff are not in the home. How well a patient improves or maintains their level of ability while getting home health care reflects both the agency's quality of service and the patient's ability to assist with the plan of care.

A few adverse event outcome measures rely on the occurrence of an emergent care encounter for specific reasons as an indicator of change in health status. These provide some of the detail behind the ***overall emergent care score***.

Case mix refers to the characteristics of the patients for whom a home health agency provides care. The case mix report presents a picture (or snapshot) of what a home health agency's patients look like at the beginning of a care episode. (The beginning of a care episode is marked by either a start of care or a resumption of care following an inpatient stay.)

These reports and the related investigation of care processes help agencies move beyond ***hunches*** in evaluating quality of patient care. Now you are able to expand quality monitoring programs to incorporate an examination of the effects of care on patients. These reports represent an important first step in truly using outcome data for quality improvement.

The case mix and adverse event outcome reports thus can be used by both HHA and by the State survey agency to assess the quality of care provided to an HHA's patients. Agencies are strongly encouraged to take advantage of the information presented in the reports for their ongoing quality-monitoring program.

Technical Documentation for the OBQM measures.

1. Quality Monitoring Using Case Mix and Adverse Event Outcome Reports This is a 5-section document that describes the OASIS-based reports that are available as well as the sources of information for the reports. It is designed to help home health agencies make use of the reports for monitoring and improving quality of care.

2. Accessing Outcome-Based Quality Monitoring Reports This document provides information to obtain Case Mix Reports and Adverse Event Outcome Reports from the OASIS state system that home health agencies already use to submit OASIS data. It describes how to request a report, how to view a report online, and how to print or save a report.

3. APPENDIX: Guidelines for Reviewing Case Mix and Adverse Event Outcome Reports This document describes in detail the component parts of the Case Mix and Adverse Event Outcome Report, and provides definitions of key terms that are essential to understanding and using the reports. It is presented as a technical appendix to the User's Manual, but can also be used as a standalone reference document. This document is formatted for two-sided printing.

4. This Technical Documentation of OBQM Measure on the adverse event and case mix reports specifies how to calculate each measure using OASIS data and OASIS data specifications.

Downloads

Quality Monitoring Using Case Mix and Adverse Event Outcome Reports [PDF 751 KB]

Accessing Outcome-Based Quality Monitoring Reports [PDF 2 MB]

APPENDIX: Guidelines for Reviewing Case Mix and Adverse Event Outcome Reports [PDF 340 KB]

Technical Documentation of OBQM Measures [PDF 225 KB]

Related Links Inside CMS

OASIS

Medicare.gov

Home Health Compare

Related Links Outside CMS

Medicare Quality Improvement Community

Agency for Healthcare Research & Quality

American Association of Home Care

National Association for Home Care and Hospice

National Association State Units on Aging

National Quality Forum

National Quality Guidelines

National Pressure Ulcer Advisory Panel

Visiting Nurse Association of America

Wound Ostomy Continence Nurses Society

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TABLE 2.2: Source(s) of Case Mix Report Information.

Case Mix Report Measures	OASIS-B1 Item(s)
Demographics	
Age (average in years)	M0066, M0090
Gender: Female (%)	M0069
Race: Black (%)	M0140
Race: White (%)	
Race: Other (%)	
Payment Source	
Any Medicare (%)	M0150
Any Medicaid (%)	
Any HMO (%)	
Medicare HMO (%)	
Any third party (%)	
Current Residence	
Own home (%)	M0300
Family member home (%)	
Current Living Situation	
Lives alone (%)	M0340
With family member (%)	
With friend (%)	
With paid help (%)	
Assisting Persons	
Person residing in home (%)	M0350
Person residing outside home (%)	
Paid help (%)	
Primary Caregiver	
Spouse/significant other (%)	M0360
Daughter/son (%)	
Other paid help (%)	
No one person (%)	
Primary Caregiver Assistance	
Freq. of assistance (0-6, scale avg.)	M0360, M0370
Inpatient DC within 14 Days of SOC/ROC	
From hospital (%)	M0175
From rehab facility (%)	
From nursing home (%)	
Med. Reg. Chg. w/in 14 Days of SOC/ROC	
Medical regimen change (%)	M0200
Prognoses	
Moderate recovery prognosis (%)	M0260
Good rehab prognosis (%)	M0270
ADL Disabilities at SOC/ROC	
Grooming (0-3, scale average)	M0640
Dress upper body (0-2, scale avg.)	M0650
Dress lower body (0-3, scale avg.)	M0660
Bathing (0-5, scale average)	M0670
Toileting (0-4, scale average)	M0680
Transferring (0-5, scale average)	M0690
Ambulation (0-5, scale average)	M0700
Eating (0-5, scale average)	M0710

Case Mix Report Measures	OASIS-B1 Item(s)
ADL Status Prior to SOC/ROC	
Grooming (0-3, scale average)	M0640
Dress upper body (0-2, scale avg.)	M0650
Dress lower body (0-3, scale avg.)	M0660
Bathing (0-5, scale average)	M0670
Toileting (0-4, scale average)	M0680
Transferring (0-5, scale average)	M0690
Ambulation (0-5, scale average)	M0700
Eating (0-5, scale average)	M0710
IADL Disabilities at SOC/ROC	
Light meal prep (0-2, scale avg.)	M0720
Transportation (0-2, scale avg.)	M0730
Laundry (0-2, scale average)	M0740
Housekeeping (0-4, scale avg.)	M0750
Shopping (0-3, scale average)	M0760
Phone use (0-5, scale average)	M0770
Mgmt. oral meds (0-2, scale avg.)	M0780
IADL Status Prior to SOC/ROC	
Light meal prep (0-2, scale avg.)	M0720
Transportation (0-2, scale avg.)	M0730
Laundry (0-2, scale average)	M0740
Housekeeping (0-4, scale avg.)	M0750
Shopping (0-3, scale average)	M0760
Phone use (0-5, scale average)	M0770
Mgmt. oral meds (0-2, scale avg.)	M0780
Respiratory Status	
Dyspnea (0-4, scale average)	M0490
Therapies Received at Home	
IV/infusion therapy (%)	M0250
Parenteral nutrition (%)	
Enteral nutrition (%)	
Sensory Status	
Vision impairment (0-2, scale avg.)	M0390
Hearing impair. (0-4, scale avg.)	M0400
Speech/language (0-5, scale avg.)	M0410
Pain	
Pain interf. w/activity (0-3, scale avg.)	M0420
Intractable pain (%)	M0430
Neuro/Emotional/Behavioral Status	
Moderate cognitive disability (%)	M0560
Severe confusion disability (%)	M0570
Severe anxiety level (%)	M0580
Behav probs > twice a week (%)	M0620
Integumentary Status	
Presence of wound/lesion (%)	M0440
Stasis ulcer(s) present (%)	M0440, M0468
Surgical wound(s) present (%)	M0440, M0482
Pressure ulcer(s) present (%)	M0440, M0450
Stage 2-4 ulcer(s) present (%)	
Stage 3-4 ulcer(s) present (%)	

TABLE 2.2: Source(s) of Case Mix Report Information. (cont'd)

Case Mix Report Measures	OASIS-B1 Item(s)
Elimination Status	
UTI within past 14 days (%)	M0510
Urinary incont./catheter present (%)	M0520
Incontinent day and night (%)	M0520, M0530
Urinary catheter (%)	M0520
Bowel incont. (0-5, scale avg.)	M0540
Acute Conditions	
Orthopedic (%)	M0175, M0180, M0190, M0200, M0210, M0220, M0250, M0280, M0440, M0500, M0520, M0550, M0630
Neurologic (%)	
Open wounds/lesions (%)	
Terminal condition (%)	
Cardiac/peripheral vascular (%)	
Pulmonary (%)	
Diabetes mellitus (%)	
Gastrointestinal disorder (%)	
Contagious/communicable (%)	
Urinary incont./catheter (%)	
Mental/emotional (%)	
Oxygen therapy (%)	
IV/infusion therapy (%)	
Enteral/parenteral nutrition (%)	
Ventilator (%)	
Chronic Conditions	
Dependence in living skills (%)	M0175, M0200, M0720, M0730, M0740, M0750, M0760, M0770
Dependence in personal care (%)	M0175, M0200, M0640, M0650, M0660, M0670
Impaired ambulation/mobility (%)	M0175, M0200, M0680, M0690, M0700
Eating disability (%)	M0175, M0200, M0710
Urinary incontinence/catheter (%)	M0175, M0200, M0220, M0520
Dependence in med. admin. (%)	M0175, M0200, M0780, M0790, M0800
Chronic pain (%)	M0175, M0200, M0220, M0430
Cognitive/mental/behavioral (%)	M0175, M0200, M0220, M0610
Chronic pt. with caregiver (%)	M0350 and any chronic condition

Case Mix Report Measures	OASIS-B1 Item(s)
Home Care Diagnoses	
Infectious/parasitic diseases (%)	M0230, M0240
Neoplasms (%)	
Endocrine/nutrit./metabolic (%)	
Blood diseases (%)	
Mental diseases (%)	
Nervous system diseases (%)	
Circulatory system diseases (%)	
Respiratory system diseases (%)	
Digestive system diseases (%)	
Genitourinary sys. diseases (%)	
Pregnancy problems (%)	
Skin/subcutaneous diseases (%)	
Musculoskeletal sys. diseases (%)	
Congenital anomalies (%)	
Ill-defined conditions (%)	
Fractures (%)	
Intracranial injury (%)	
Other injury (%)	
Iatrogenic conditions (%)	
Length of Stay	
LOS until discharge (avg. in days)	M0100, M0030, M0032, M0906
LOS from 1 to 31 days (%)	
LOS from 32 to 62 days (%)	
LOS from 63 to 124 days (%)	
LOS more than 124 days (%)	

The characteristics of the patients for whom your agency provides care will affect many decisions you make about patient care delivery, including:

- need to develop or modify policies, procedures, or protocols;
- possible care path development, or disease management approaches;
- decisions about obtaining or developing patient education materials; and
- examining potential areas where increased care coordination may be indicated.

Home Health Quality Initiatives

Content Section

OASIS OBQI

This page holds the OBQI Manuals, documents about risk adjustment for OASIS measures, a revised Patient Tally filter tool with branch reports (October 2006), and documents that refines risk-adjustment (January 2005). The document was updated in January 2005 to include the how numeric ICD9 values from M0245 would be used in the computation of some risk factors used in risk adjustment.

1. Outcome-Based Quality Improvement (OBQI) Implementation Manual

This is a 10-chapter manual that describes the OASIS-based reports that are available through the state OASIS system. This manual is written for HHA staff who wishes to learn how to read and interpret the OBQI reports, and who wish to implement the outcome enhancement activities of OBQI in response to the outcome reports. The Appendix A

definitions of key terms that are essential to understanding and using the reports.

Additions to the OBQI Manual: Appendix C is available in a crosswalk format that indicates which OASIS items are used for each specific outcome measure included in the OBQI reports. The Table of Contents file is also updated to include the new appendix.

2. Accessing OBQI & OBQM Reports - Using the CASPER Reporting System

This document provides information to obtain Case Mix reports, Adverse Event Reports, Patient Risk-adjusted and Descriptive Outcome Reports, and patient tally reports for case mix and outcomes measures from the OASIS state system that home health agencies already use to submit OASIS data. It describes how to request a report, how to view a report online, and how to save and print a report.

3. Supplement to the OBQI manual

This document is a supplement to the OBQI manual listed above in 1. This supplement covers the 3-bar outcome reports and 3-column case mix reports. The PDF file contains a brief narrative followed by an appendix with illustrative reports and a second appendix with the "how-to read" guidelines. It is recommended that home health agencies download this Supplement and add it to their existing OBQI Manual. The guidelines in Appendix B *Basic Information Regarding the Outcome and Case Mix Reports* should be shared with individuals who review your reports.

Downloads

OBQI Implementation Manual (September 2002) [ZIP 3.5 MB]
Accessing OBQI & OBQM Reports - Using the CASPER Reporting System
Supplement to the OBQI manual (May 2003) [PDF 1069 KB]

Overview of Risk Adjustment and Outcome Measures for Home Health Agency OBQI Reports: Highlights of Current Approaches and Outline of Planned Enhancement [PDF 792 KB]

Documentation of Prediction Models Used for Risk Adjustment of Home

Health Agency Outcomes Reported on the CMS Home Health Compare Web Site [PDF 1.8 MB]

Appendix A: Documentation of Prediction Models Used for Risk Adjustment of Home Health Agency Outcome Reports [PDF 3 MB]

Appendix B: Outcome-Based Quality Improvement Reports: Technical Documentation of Measures [PDF 4 MB]

Appendix B: Case Mix Modification (1/2005) [PDF 68KB]
Appendix B: Risk Factors Modification (1/2005) [PDF 38KB]

Revised Patient Tally Report Workbook with Data Filtering Tools [ZIP 432 KB]

Refinement of Risk-Adjustment for OBQI Reports (April 2003) [PDF 27 KB]

Related Links Inside CMS

OASIS
Medicare.gov
Home Health Compare

Related Links Outside CMS

Medicare Quality Improvement Community
Agency for Healthcare Research & Quality
American Association of Home Care
National Association for Home Care and Hospice
National Association State Units on Aging
National Quality Forum
National Quality Guidelines
National Pressure Ulcer Advisory Panel
Visiting Nurse Association of America
Wound Ostomy Continence Nurses Society

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TABLE 3.2: Source(s) of Adverse Event Outcome Report Information.

Adverse Event Outcome Report Measures	OASIS-B1 Item(s) and Time Point(s)
Emergent Care for Injury Caused by Fall or Accident at Home	M0830 (Transfer/Discharge) M0840 (Transfer/Discharge)
Emergent Care for Wound Infections, Deteriorating Wound Status	
Emergent Care for Improper Medication Administration, Medication Side Effects	
Emergent Care for Hypo/Hyperglycemia	
Development of Urinary Tract Infection	M0510 (SOC/ROC and Discharge)
Increase in Number of Pressure Ulcers	M0450 (SOC/ROC and Discharge)
Substantial Decline in Three or More Activities in Daily Living	M0280 (SOC/ROC) M0640, M0670, M0680, M0690, M0700 (SOC/ROC and Discharge)
Substantial Decline in Management of Oral Medications	M0780 (SOC/ROC and Discharge)
Unexpected Nursing Home Admission	M0270 (SOC/ROC) M0900 (Transfer/Discharge)
Unexpected Death	M0280 (SOC/ROC) M0100 (Discharge/Transfer/Death)
Discharged to Community Needing Wound Care or Medication Assistance	M0300, M0350, M0460, M0488, M0570, M0780, M0870 (Discharge)
Discharged to Community Needing Toileting Assistance	M0350, M0680, M0700, M0870 (Discharge)
Discharged to Community with Behavioral Problems	M0350, M0610, M0870 (Discharge)

emergency room or physician's office at the very first sign of deteriorating wound status. This would be an example of appropriate care. However, the agency may also find situations where a wound's status was getting worse and worse and worse over the period of several visits -- and the responsible clinician was not responding in any way to this deterioration in status. This would be determined to be inadequate care, and in this case the adverse event indicates a problem in patient care.

Whether or not the care for a patient listed on the tabular adverse event outcome report was problematic cannot be known until the agency actually investigates the care provided. Guidance on conducting an investigation of care provided is detailed in Section 4 of this manual.

OASIS Items Used in Calculation of Outcome Measures Appearing in OBQI Reports

RISK-ADJUSTED OUTCOME REPORT

Outcome Measure	OASIS Items Used
All Outcome Measures	M0066 Birth Date (at SOC/ROC) M0090 Date Assessment Completed (at SOC/ROC, used to calculate age; patient must be at least 18 and no more than 120 years) M0100 Reason for Assessment (episode must begin with RFA = 01, 02, or 03, and end with RFA = 06, 07, or 09) M0570 When Confused (at SOC/ROC, must not = NA Patient nonresponsive) M0580 When Anxious (at SOC/ROC, must not = NA Patient nonresponsive)
All End-Result Outcome Measures	M0100 Reason for Assessment (episode must end with RFA = 09)
Improvement in Grooming	M0640 Grooming (at SOC/ROC and at Discharge)
Stabilization in Grooming	M0640 Grooming (at SOC/ROC and at Discharge)
Improvement in Upper Body Dressing	M0650 Ability to Dress Upper Body (at SOC/ROC and at Discharge)
Improvement in Lower Body Dressing	M0660 Ability to Dress Lower Body (at SOC/ROC and at Discharge)
Improvement in Bathing	M0670 Bathing (at SOC/ROC and at Discharge)
Stabilization in Bathing	M0670 Bathing (at SOC/ROC and at Discharge)
Improvement in Toileting	M0680 Toileting (at SOC/ROC and at Discharge)
Improvement in Transferring	M0690 Transferring (at SOC/ROC and at Discharge)
Stabilization in Transferring	M0690 Transferring (at SOC/ROC and at Discharge)
Improvement in Ambulation/Locomotion	M0700 Ambulation/Locomotion (at SOC/ROC and at Discharge)
Improvement in Eating	M0710 Feeding or Eating (at SOC/ROC and at Discharge)
Improvement in Light Meal Preparation	M0720 Planning and Preparing Light Meals (at SOC/ROC and at Discharge)
Stabilization in Light Meal Preparation	M0720 Planning and Preparing Light Meals (at SOC/ROC and at Discharge)
Improvement in Laundry	M0740 Laundry (at SOC/ROC and at Discharge)
Stabilization in Laundry	M0740 Laundry (at SOC/ROC and at Discharge)
Improvement in Housekeeping	M0750 Housekeeping (at SOC/ROC and at Discharge)
Stabilization in Housekeeping	M0750 Housekeeping (at SOC/ROC and at Discharge)

RISK ADJUSTED OUTCOME REPORT (Cont'd)

Outcome Measure	OASIS Items Used
Improvement in Shopping	M0760 Shopping (at SOC/ROC and at Discharge)
Stabilization in Shopping	M0760 Shopping (at SOC/ROC and at Discharge)
Improvement in Phone Use	M0770 Ability to Use Telephone (at SOC/ROC and at Discharge)
Stabilization in Phone Use	M0770 Ability to Use Telephone (at SOC/ROC and at Discharge)
Improvement in Management of Oral Medications	M0780 Management of Oral Medications (at SOC/ROC and at Discharge)
Improvement in Dyspnea	M0490 Short of Breath (at SOC/ROC and at Discharge)
Improvement in Urinary Tract Infection	M0510 Urinary Tract Infection (at SOC/ROC and at Discharge)
Improvement in Urinary Incontinence	M0520 Urinary Incontinence or Urinary Catheter Presence (at SOC/ROC and at Discharge) M0530 Urinary Incontinence (at SOC/ROC and at Discharge)
Improvement in Bowel Incontinence	M0540 Bowel Incontinence Frequency (at SOC/ROC and at Discharge)
Improvement in Confusion Frequency	M0570 When Confused (at SOC/ROC and at Discharge)
Utilization Outcome Measures	
Discharged to Community	M0100 Reason for Assessment (at Discharge or Transfer) M0870 Discharge Disposition (at Discharge)
Acute Care Hospitalization	M0100 Reason for Assessment (at Discharge or Transfer) M0855 Inpatient Facility (at Transfer)

DESCRIPTIVE OUTCOME REPORT

Outcome Measure	OASIS Items Used
All Outcome Measures	M0066 Birth Date (at SOC/ROC) M0090 Date Assessment Completed (at SOC/ROC, used to calculate age; patient must be at least 18 and no more than 120 years) M0100 Reason for Assessment (episode must begin with RFA = 01, 02, or 03, and end with RFA = 06, 07, or 09) M0570 When Confused (at SOC/ROC, must not = NA Patient nonresponsive) M0580 When Anxious (at SOC/ROC, must not = NA Patient nonresponsive)
All End-Result Outcome Measures	M0100 Reason for Assessment (episode must end with RFA = 09)
Stabilization in Management of Oral Medications	M0780 Management of Oral Medications (at SOC/ROC and at Discharge)
Improvement in Speech and Language	M0410 Speech and Oral (Verbal) Expression of Language (at SOC/ROC and at Discharge)
Stabilization in Speech and Language	M0410 Speech and Oral (Verbal) Expression of Language (at SOC/ROC and at Discharge)
Improvement in Pain Interfering with Activity	M0420 Frequency of Pain (at SOC/ROC and at Discharge)
Improvement in Number of Surgical Wounds	M0440 Skin Lesion/Open Wound (at SOC/ROC and at Discharge) M0482 Surgical Wound (at SOC/ROC and at Discharge) M0484 Current Number of (Observable) Surgical Wounds (at SOC/ROC and at Discharge)
Improvement in Status of Surgical Wounds	M0440 Skin Lesion/Open Wound (at SOC/ROC and at Discharge) M0482 Surgical Wound (at SOC/ROC and at Discharge) M0488 Status of Most Problematic (Observable) Surgical Wound (at SOC/ROC and at Discharge)
Improvement in Cognitive Functioning	M0560 Cognitive Functioning (at SOC/ROC and at Discharge)
Stabilization in Cognitive Functioning	M0560 Cognitive Functioning (at SOC/ROC and at Discharge)
Improvement in Anxiety Level	M0580 When Anxious (at SOC/ROC and at Discharge)
Stabilization in Anxiety level	M0580 When Anxious (at SOC/ROC and at Discharge)
Improvement in Behavior Problem Frequency	M0620 Frequency of Behavior Problems (at SOC/ROC and at Discharge)
Utilization Outcome Measures	
Any Emergent Care Provided	M0830 Emergent Care (at Discharge or Transfer)